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Cataloging information

GUMBINER, Robert (b. 1923)

Physician-HMO founder

FHP: The Evolution of a Managed Care Health Maintenance Organization, 1955-1992, 1994, xi, 458 pp.

Indiana background: medical school, internship, and general practice; move to California, 1949, and working in both fee-for-service and HMO-style settings; Lakewood Plaza Medical Group, and the Family Health Program [FHP]: group practice, recruiting patients, fee-for-service vs. prepayment medicine, medical and social ostracism; FHP, Inc.: growth since 1966, California State Attorney General's office files suits regarding Medi-Cal and for-profit conversion, building hospitals and medical centers, expansion to Guam and Utah, matrix management system; discusses prioritizing medical care, the personal physician, management style. Includes interviews with nine former and present FHP employees, with early association or with key positions in the company: R. Colleen Bennett (b. 1934); Burke F. Gumbiner (b. 1950); Harold W. Johnson, III (b. 1944); David LeSueur (b. 1949); Charles A. Lifschultz (b. 1948); Jack D. Massimino (b. 1949); Raymond W. Pingle (b. 1947); Westcott W. Price, III (b. 1939); and Henry Schultz (b. 1915).

Introductions by George Kimbrough, FHP staff physician, and Alis Gumbiner, daughter.

Interviewed 1991-1992 by Sally Smith Hughes. Regional Oral History Office, The Bancroft Library, University of California, Berkeley.

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INTRODUCTION--by George Kimbrough

I first laid eyes on Robert Gumbiner two weeks after I became a staff physician at FHP. He was inspecting the medical center (Compton) where I was starting my FHP career.

The operations manager of the center passed the word that he was on his way. I was eager to meet him and thank him for tickets to an upcoming performance of the Los Angeles Philharmonic. ("What an appropriate welcome gift! How did he know we were music lovers? What efficiency!")

A hush had fallen over the center while the inspection was under way. When I heard him outside the doctors' lounge I stood up in anticipation. At the door he looked into the lounge and right at and through me. He was focused on finding any fault and, in a hasty glance, apparently found none.

I learned that this intensity of focus was as characteristic of him as is his tight muscle tone as seen on the tennis court or swimming in the Bay, and as characteristic as the wide space between his upper middle incisor teeth (which some anthropologists hold is a mark of artists and high achievers).

During the inspection, though, I felt ignored and I couldn't fit that in with the concert tickets. I was to learn by his remarks later that he may hold doctors in low esteem even though he is one and he is the son of a family doctor. "Oh, yeah, doctors: they pee in the sink, screw their nurse, and lie about their income tax."

Maybe this remark wasn't criticism after all, but behavioral excuse. "Doctors are so busy caring for others, they don't have time to go to the toilet or socialize outside home and office, and they are ashamed that they charge so little so they pad their income tax returns."

After twenty years in private practice in Louisville, Kentucky I was glad to give up the business of medicine and take my practice of the art of medicine to southern California. Dr. Gumbiner had studied health care management and had written a book about it (HMO: Putting it all Together). I knew I was in good hands and I wanted to provide good hands for the patients I would serve.

To heighten my happiness at the change, I had a colleague who was another ex-private practitioner who had left FHP for a trial with another HMO and had come back to FHP. Bob Moline reminded me of inspiring doctors I had known. We became fast friends fast. He had some grand Gumbiner stories to tell. Patient telephoning: "Dr. Gumbiner, please send some penicillin tablets for my son's sore throat." Robert Gumbiner:

"Wait a minute. Hold your son's throat up to the phone so I can see if that's what he needs." The patient brought her son in.

Another pet feature of the Gumbiner medical practice is the annual health screen. It was new to me. I had been trained to diagnose and treat disease, not prevent disease. The Gumbiner Way (perhaps lifted from the Chinese--pay when well and don't pay when sick) made sense, and I could counter the bitching of those who had to do the health screens. Through the health screens we could remind people about risky habits--overeating, abusing alcohol, smoking, driving without seatbelts, etc. And we could offer Health Education Classes. Thus we could prevent illness and disability while growing the bottom line.

This introduction is a little long. (Another Gumbinerism: "Any report over a page long is padded and I won't read it.") Please read on.

Robert Gumbiner has used his talents for the benefit of doctors and patients by creating a health care system that is effective and not wasteful. To start an HMO in the sixties, to persevere and to win shows he was the right man in the right place at the right time.

The staff of FHP has grown from forty physicians when my wife, Laura, and I joined in 1975 to over six hundred physicians now in the summer of 1993. What Robert Gumbiner has created promises to fit in smoothly with what is foretold about the Clinton health plan.

George Kimbrough
staff physician, FHP

September 1993
Long Beach, California

INTRODUCTION--by Alis Gumbiner

Writing about a man you have known, quite literally, for a lifetime is rarely a simple task. Memories form a kaleidoscope of images, each offering up a different facet of the individual. In the case of Robert Gumbiner, a man whose life in and of itself contains so many facets, the task of presenting a single clear and lucid sketch is doubly hard. Separating the personal man from the professional figure is made more difficult by the complexity of the man's mind and personality.

One sketch might be drawn of Robert Gumbiner the father. While he was undoubtedly a dominant influence in my life and those of my brothers, I think we recognized even as young children that we were dealing with something of an eccentric. He was certainly not the father portrayed in television shows--steady, calm, and predictable. He was far more likely to go skinny-dipping in the swimming pool or descend on the kitchen at one a.m., dressed in his bathrobe and rattling a box of breakfast cereal in a not-so-subtle message that it was time for our teenage cronies to go home.

He did occasionally attempt to conform to middle-class America's notions of family outings. I have vague and distant memories of a single camping trip to the Grand Canyon, complete with burnt campfire pancakes and a homemade luggage rack that blew off the top of the car. Trips more suited to his personal tastes were driving the length of Baja with my brothers (before the highway was built), trekking in Nepal, or scuba diving in the western Pacific.

So another sketch should be rendered of Robert Gumbiner the traveller. As far back as I can remember, he has sought out new experiences and unknown places, often for as little reason as "I've never been there" or in the case of business/pleasure trips, "it was on the way and I'd never been there." These trips were not always comfortable (he managed to land in Darwin one Christmas Eve, just ahead of the hurricane that flattened 95 percent of the city) but they always contained a bit of adventure and generated any number of tall tales. As a result, he imbued all of his children with a passion for travel that borders on obsession.

Other passions in his life have been art and design. But like the father and the traveller, Robert Gumbiner the art collector has never been, well, conforming. He collects strange and sometimes wonderful things, representative and abstract, usually figurative in nature, sometimes sexual in orientation, and rarely like anything you've seen hanging on someone else's walls. And Robert Gumbiner the designer exhibits an attention to detail that has been the despair of more than one contractor (I believe he actually went through three different

contractors in the five years he spent building his house). His vision of what he likes and wants may be skewed from the norm, but it's always completely focused.

That characteristic of being able to focus, intensely, on the project at hand, is of course one of the things that made Robert Gumbiner so successful in business. I was vaguely aware, as children are, that Dad worked hard at what he did. He was gone six days a weeks, fourteen hours a day. When he finally made it home, he often disappeared immediately into his study, working long after the rest of us had presumably gone to bed (which explains why he was on hand with that cereal box at one a.m.). Yet I didn't realize, until I was well into my teens, that what he had built was so impressive. I remember the actual moment of revelation, standing outside FHP's new medical building in downtown Long Beach and thinking, "Wow, Dad has a big business here."

But I'm still not clear, to this day, that building a "big" business was really all that important to him. I think the important thing was the challenge. One of his favorite sayings has always been, "The minute someone says it can't be done, I start looking for ways to do it." He was told people wouldn't go for prepaid group health, so he set out to prove the nay-sayers wrong. That he became a leader in the HMO industry and built a hugely successful company along the way is not incidental, but neither, do I think, was that the true motivation.

His motivation was that of the entrepreneur--to do it differently than it's been done before, build a better mousetrap, accomplish something others say is impossible. Robert Gumbiner's entrepreneurial drive and creative energy are apparent in many aspects of his multi-faceted life. Where other people in Long Beach saw a dilapidated old roller-skating rink--the Hippodrome--he saw a wonderful old building that could be restored and recast in a new role (it's now FHP's Senior Center). Where another man, trained as a doctor for a variety of reasons having little to do with true inclination, may have just toddled along, treating patients and building a practice, he saw a way to take that training, combine it with his other interests, and build something more.

Perhaps the reason it is so difficult to draw a clear, concise portrait of Robert Gumbiner is because he does have so many interests, each pursued with equal intensity and usually simultaneously. Ask any six of his friends and acquaintances to describe the man and you'll get a result akin to the six blind men describing the elephant: he's kind, he's hard, he's judgmental, he's ultimately reasonable, he's stubborn, he's creative, and the list goes on and on. None of these descriptions are completely false yet none are truly complete.

My father once told me, "My advantage is I can think about ten different things all at the same time." That's true. He also seems to

do ten different things simultaneously, probably because he considers concentrating on only one thing a waste of precious time. Whether you view this as a flaw or a talent usually depends on how capable you are of keeping up with him.

Alis Gumbiner

July 30, 1993
Los Angeles, California

VOLUME HISTORY--by Sally Smith Hughes

The purpose of the series is to document the history and leadership of FHP (originally called Family Health Program), a major health maintenance organization [HMO] located in southern California. Its history is captured through an extensive, in-depth oral history with its founder and long-term director, Dr. Robert Gumbiner, and through nine short interviews with some of his key associates.

The Regional Oral History Office [ROHO] had recently completed its oral history series on the Kaiser Permanente Medical Program, when it received a call in 1991 from Dr. Gumbiner, inquiring about the possibility of an oral history of FHP. The chance to document the history of an HMO which has evolved through various methods of delivering health care was intriguing. A history of FHP would serve as a valuable historical complement to the Kaiser series, allowing comparison of two different HMO models: FHP is a staff model HMO in which physicians are employees of the company, whereas Kaiser Permanente is an independent medical group model in which the regional Permanente Medical Groups contract annually with Kaiser Health Plan.

The proposed project was also an opportunity to record the life story of Robert Gumbiner, FHP's colorful founder, whose personal history, philosophy, and business practices are intimately intertwined with those of the company. We are grateful to FHP, Inc. for underwriting the oral histories.

The interviewer made three short trips to southern California between November 1991 and February 1992. On the first trip, I met with Dr. Gumbiner to plan the project, to do research in documents available at FHP's corporate offices in Fountain Valley, and to begin the interviews with Dr. Gumbiner. He chose nine FHP employees to be interviewed on the basis of their early association with FHP and/or key position in the company.¹ The fact that only one, Charles Lipschultz, is a physician may reflect Dr. Gumbiner's predominantly business rather than medical orientation.

On the second trip, I continued the interviews with Dr. Gumbiner and my research on FHP. I reviewed binders containing FHP newsletters and brochures, and copies of Dr. Gumbiner's speeches (1970s) and position papers (1970-1975). Annual reports are available beginning in 1986 when the company became publicly held as FHP International Corporation. Formation of an FHP archives was being contemplated at the time of the

¹ All the interviewees continue to work for FHP with the exceptions of Harold Johnson, David LeSueur, and Henry Schultz.

interviews. There is also a collection of corporate photographs which is the source of most of those illustrating the oral history. The family photographs come from Dr. Gumbiner's personal collection.

The third trip was an intense experience. I concluded my research and the interviews with Dr. Gumbiner and conducted eight of the nine short interviews with his associates.¹ All of the short interviews were conducted at FHP's corporate offices with the exception of the three conducted by telephone (Bennett, Johnson, LeSueur).

The short interviews were a challenge. In some instances, I did not receive curricula vitae in advance and the few sentences Dr. Gumbiner wrote about each interviewee were not sufficient to indicate all relevant topics for discussion. Instead, I based my questions on a chronological list of important events in FHP history. Four interviewees were only available for an hour or less, and of the three I interviewed by telephone, two I never met face to face. Despite these minor drawbacks, the short interviews augment and amplify Dr. Gumbiner's account.

The interviews were lightly edited and mailed to the participants, who reviewed and corrected them. I wish to thank Colleen Bennett, Dr. Gumbiner's secretary for twenty-four years, for her essential role as FHP project coordinator. She arranged interviews, provided documents and photographs, and retyped the entire oral history after Dr. Gumbiner had corrected it. Both the interviewer and Shannon Page, editorial assistant, went over the transcripts a final time, making a few changes and eliminating some redundancies. The references cited in footnotes are located in FHP's corporate offices in Fountain Valley.

The Regional Oral History Office was established in 1954 to augment through tape-recorded memoirs the Library's materials on the history of California and the West. The office is under the direction of Willa K. Baum, and is an administrative division of The Bancroft Library of the University of California, Berkeley.

Sally Smith Hughes, Ph.D.
Interviewer/editor

August 1993
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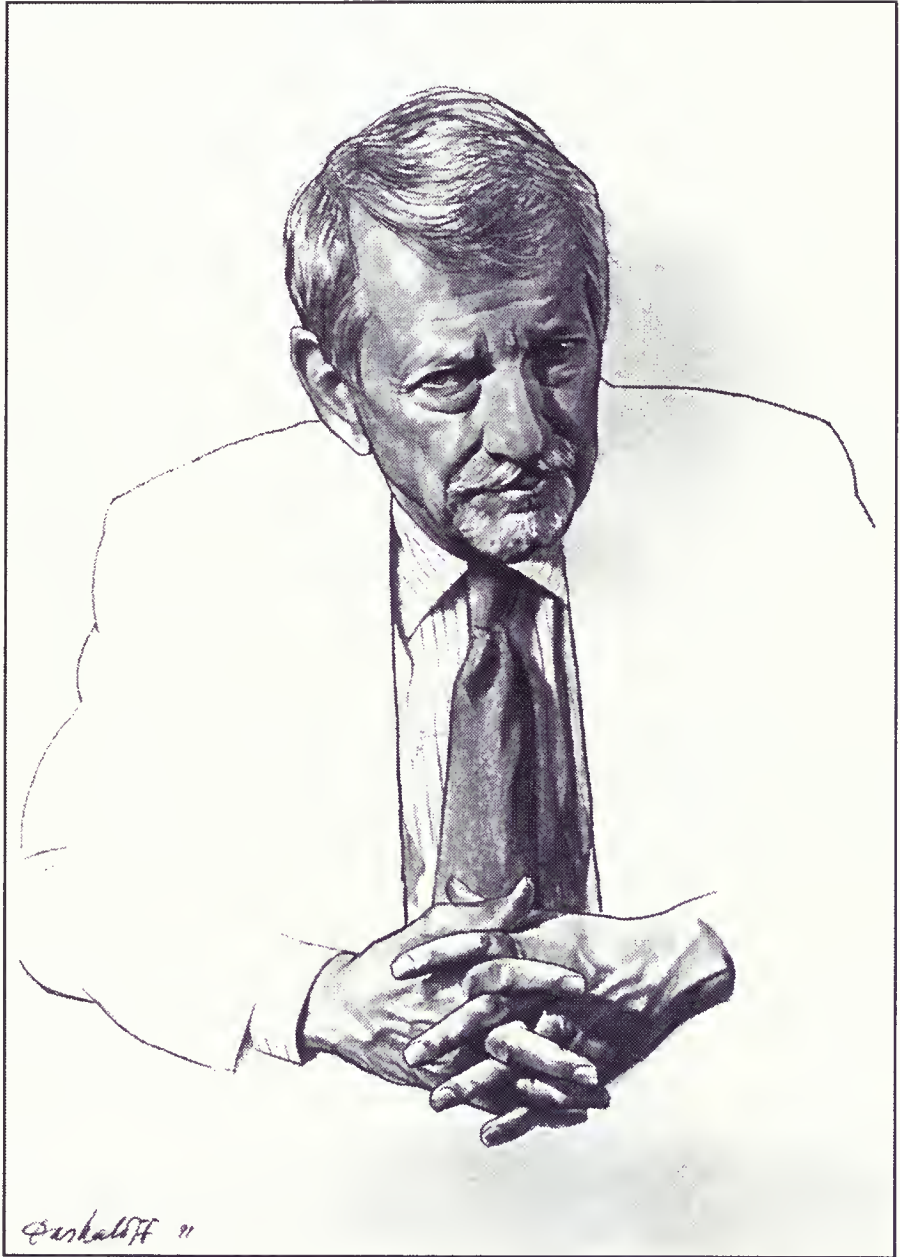
¹The ninth short interview, with Colleen Bennett, was conducted by telephone from the San Francisco Bay Area.

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AN INTERVIEW WITH ROBERT GUMBINER, M.D.

Interviews Conducted by
Sally Smith Hughes
1991-1992



Robert Gumbiner, 1992.

INTERVIEW HISTORY--by Sally Smith Hughes

Robert Gumbiner, M.D. is a study in contrasts. He is a man of short stature and large presence in terms of personality and influence on FHP, the health maintenance organization [HMO] which he created and directed for almost thirty years. He is an entrepreneur par excellence--innovative, driving, visionary, risk-taking. He is also a hard-headed businessman who believes health delivery should be based on solid business principles. His views on comprehensive, cost-effective prepaid health care delivery are of particular interest in the present national climate of concern over soaring health-care costs and inefficiencies.

Deciding early that the everyday practice of medicine was "boring!" he established over time a comprehensive, prepaid health care delivery system based on the twin pillars of patient benefit and sound business. In the process, he struggled with just about every institution he encountered: fee-for-service medicine, his group practice partners, competing HMOs, the federal and state governments, Group Health Association of America, and, after FHP became publicly held in 1986, Wall Street investors.

Robert Gumbiner is a man with a vision: to provide quality medicine at an affordable price and simultaneously control costs by ensuring adequate but not excessive health care for every FHP member. But he also has practical ideas about how to make comprehensive health care available and accessible to people of modest means. Implementation of this system has been a major goal of his life and, not surprisingly, the major topic of this oral history.

Dr. Gumbiner combines the qualities of supreme self-confidence and brusqueness with a sharp sense of humor and a genuine desire to assist the poor, the aged, and the disenfranchised. Of interest in the latter regard is his account in the oral history of his trip to Mississippi to participate in the civil rights movement. Some years later, he persuaded the state of California to back his Medi-Cal [California's Medicaid program] project which provided comprehensive prepaid medical, hospital, dental, and psychiatric care to the indigent at a lower cost to the state than fee-for-service medicine offered for the same services. It was the first successful prepayment plan for Medicaid in the nation. He later established FHP's senior plan and senior medical centers to serve the elderly.

Of particular interest to students of the health care industry is Dr. Gumbiner's description of FHP's evolution through virtually every major mode of health care delivery in the United States. Starting as a solo general practitioner in Long Beach in 1950, he soon built the Plaza Medical Group, a ten-doctor fee-for-service group practice. Dissatisfied

with the fee-for-service system, in 1960 Dr. Gumbiner established a group practice prepayment program called Family Health Program. Originally confined to the patients of the Plaza Medical Group, he soon expanded services to local school and city employee groups and eventually to state and federal employees. By 1966 the Family Health Program had become a totally prepaid group practice whose name was eventually shortened to FHP.

In 1973 FHP expanded to the island of Guam, offering medical services as a "staff model" HMO,¹ in which physicians are employees rather than partners. Under the rubric of "dual choice", which gives individuals a choice of medical insurance plans, FHP introduced an Independent Practice Association (IPA) to the island the following year.

In 1980 FHP became a hospital-based operation; its first hospital opened in 1986. Requiring capital for rapid geographic expansion, FHP converted from nonprofit to for-profit status in 1985, becoming a publicly held corporation the following year. 1986 also saw FHP's expansion to Arizona and New Mexico, where the IPA system pioneered on Guam proved useful for rapid penetration of new geographic areas. By 1992 FHP was providing managed health care services to more than 715,000 members in California, Arizona, Utah, Guam, Saipan, New Mexico, and Nevada.²

In the oral history, Dr. Gumbiner provides the details of the foregoing developments and much more, embellished with anecdotes which simultaneously inform, amuse, and reveal his acerbic view of human nature.

INTERVIEW PROCESS

The six interviews with Dr. Gumbiner were conducted between November 5, 1991 and February 18, 1992 in his attractive home on the harbor in Long Beach. Works of art, largely pre-Columbian statuary which he avidly collects, were everywhere in evidence. The interviews were a challenge. Dr. Gumbiner's provocative manner at times turned the discussion into a duel of wits. However, his feistiness is leavened by a sense of humor and a directness which the reader will readily detect in the dialogue. I enjoyed the experience.

¹The reader may wish to consult ROHO's twenty-volume oral history series, "History of the Kaiser Permanente Medical Care Program," which describes an independent medical group model HMO.

² FHP International Corporation 1992 Annual Report, p. 2.

Dr. Gumbiner was in fact a very good subject. In general, he spoke fully and with good recall, at times returning to themes which he wished to emphasize. The interviews were occasionally interrupted by one or the other of his two home secretaries (in addition to Colleen Bennett at the corporate offices) who handle his many business and public service enterprises in his so-called retirement. (Dr. Gumbiner retired as CEO from FHP in November 1990 but remains chairman of the board of directors.)

The interviews were lightly edited and mailed to Dr. Gumbiner who reviewed and corrected them. Colleen Bennett retyped the transcripts, in the process taming some of Dr. Gumbiner's fiery prose. Both the interviewer and Shannon Page, editorial assistant, went over the transcripts again, making a few changes and eliminating some redundancies. The references cited in the footnotes are located in FHP's corporate offices in Fountain Valley, California.

This oral history is the document of a tenacious visionary and a practical man of business, who fought his way through formidable obstacles to achieve his goal of providing affordable and accessible quality health care to members of FHP. But the final chapters have not been recorded. Dr. Gumbiner is currently using his wide knowledge of health care systems to contribute to the reshaping of health services in the United States and abroad.

Sally Smith Hughes, Ph.D.
Interviewer/editor

August 1993
Regional Oral History Office
The Bancroft Library
University of California, Berkeley

BIOGRAPHICAL INFORMATION

(Please write clearly. Use black ink.)

Your full name ROBERT GUMBINER

Date of birth Jan. 31, 1923 Birthplace St. Louis, MO

Father's full name Benjamin Gumbiner

Occupation Physician Birthplace Belle Plain, Iowa

Mother's full name Anna Bleiweiss Gumbiner Barney

Occupation Homemaker Birthplace Chicago, Illinois

Your spouse not married

Your children Alis Susan, Burke Franklin, Jay Michael, Lee Allan

Where did you grow up? Gary, Indiana

Present community Long Beach, California

Education Indiana University; BS, 1944

Indiana University School of Medicine; MD, 1948

Occupation(s) Physician - Manager

Areas of expertise Development and management of health care

delivery services

Other interests or activities Writing, Comparative health care

systems, Cycling, Tennis, Skiing

Organizations in which you are active

Board of Governors, CA State University, Long Beach

Democratic National Committee

International Society for Technology Assessment in Health Care

Hippodrome Gallery

FHP Foundation

I FAMILY BACKGROUND AND EDUCATION

[Interview 1: November 5, 1991] ###¹

Parents

Hughes: Dr. Gumbiner, I want to start with your family history as far back as you can remember.

Gumbiner: Well, my father, Benjamin Franklin Gumbiner, was a physician in Gary, Indiana, a town of 100,000 people. So I knew something about health care.

Hughes: Was he a general practitioner?

Gumbiner: He was a general practitioner. I can remember in the big Depression of 32 and 33 how tough it was for doctors, particularly in a one-industry town like Gary, Indiana, which was a steel mill town. Instead of laying people off, they'd give them only one or two days a week, to keep their work force there. Of course no one could live on one or two days' work, so they would do things like draining the swamps to the south of the town, or give everybody seeds and tools and tell them to go out there and raise their own food.

At home we always had people painting the house, doing yard work and things of that nature, in order to pay for their medical bills. In those days there wasn't any such thing as medical insurance. Organized medicine was against insurance in the old days, if you can recall that. They thought that health insurance was some kind of communist plot, and they eventually

¹### This symbol indicates that a tape or segment of a tape has begun or ended. A guide to the tapes follows the transcript.

fought against Medicare also, even though Medicare and insurance made most doctors fairly wealthy. In those days there wasn't any insurance so the doctors would fight over the few scraps there were, such as county welfare patients, which was the only cash crop around there, you might say.

Strange as it may seem, I'd visit my father in his office after school and he'd be playing gin rummy or chatting with the doctor next door. Where were the sick people? Well, in hard times the sick people don't get care, that's all. They use home remedies, or if the kid breaks his leg and if it isn't too crooked, they don't take him to the doctor, instead they just let it heal itself. His foot has to be on backwards before they take him to see the doctor. Then, of course, they wouldn't pay the doctor because they couldn't.

The doctors these days don't realized what a great situation they have because the bills are all paid by either insurance (at least in most part), or by Medicare, or Medi-Cal, or one of the other government programs.

Hughes: Did you struggle as a family?

Gumbiner: I can remember when it was pretty rough to get a nickel for a candy bar. They were building a road and I would sell pop to the guys that were building the road. I'd put soft drinks in a big tub of ice and haul it up to them in a wagon until I sold enough pop to them to buy a bicycle.

It was pretty thin in those days, even for a physician. I think in the neighborhood that we lived in, my father's house was probably the only one that wasn't foreclosed on. In order to make a living doctors had to have evening office hours, Saturday office hours, and make rounds on Sundays.

They always had to have their office open when the mill had a payday--the workers in the mill all engaged in deficit financing. That is to say, they would take their pay check, cash it at their local bar, and go down Main Street to pay off all the merchants, doctors, and others that they had owed money to the last month. What they had left was what they had left, which was very little. They would start charging again for the next month. So, if you weren't at your office or place of business when the mill paid, you got left out; they would pay off the next person instead, or they'd have a little more left at the end of the month, or they'd have a couple more beers at the bar at the end of the road.

Hughes: Did your father have a way of handling that?

Gumbiner: Yes, he was always in the office during payday. That was his way of handling it. [laughter]

Hughes: Where was he educated?

Gumbiner: He came from a little town in Iowa called Belleplain, where he was born and raised. My grandfather, Louis Robert Gumbiner, owned a general store. When my father graduated from a small high school, which had about six or eight people in the graduating class, he asked his principal what he should do. The principal said, "Well, you ought to become a doctor." He asked him where he should go, and the principal said, "You ought to go to the University of Chicago." His father took him into the back of the store, took a man's suit and cut off the arms and legs, gave him a couple of sets of long underwear (because he was going to Chicago), and he took his basketball and violin and went to the University of Chicago.

Hughes: He'd done well in school?

Gumbiner: I guess.

Hughes: What happened at the University of Chicago? That's Rush Medical School?

Gumbiner: Yes, he went to undergraduate at University of Chicago and then he went to Rush Medical. I guess the navy sent him to school in World War I. After all that, he went to St. Louis, to St. Louis City Charity Hospital, to take his internship. Then he went right across the river to a small town in southern Illinois called Benald and started a general practice. I was born in St. Louis because they didn't have a hospital in this little town.

Hughes: You'd better bring your mother into this.

Gumbiner: My mother? Oh yes. Well, he married my mother somewhere along there. [laughter] Her maiden name was Anne Bleiweiss. I guess he met her in Chicago.

Hughes: What was her story?

Gumbiner: She didn't have much of a story. She was the youngest of six children, lived in Chicago, and her father was a tailor. I guess she met my father one summer when he was working there between semesters, and later on they got married.

Hughes: The navy was putting him through medical school?

Gumbiner: The usual situation that you had in World War I and World War II was that everybody in medical school volunteered for the service. (I had the same situation in World War II.) They just put you in uniform, reassigned you back to medical school, and paid your way through medical school.

Hughes: Tell me what your parents were like as personalities.

Gumbiner: Oh, my father was a conservative type of person. He took about one vacation, that I know of, in twenty years. He got out of school in about 1918 or 1919, went into practice in the early twenties in a small town in Illinois, built up a general practice, and then moved to Gary, Indiana. My mother's family was nearby in Chicago. Gary was a mill town and he built up another practice in the late twenties. Then, all of a sudden, we had the Depression of 1929.

Hughes: Why did he move to Gary?

Gumbiner: He moved there, I think, because my mother wanted to move back near her family in Chicago.

Incidentally, he and two other doctors started a group practice when he first arrived in Gary. However, it proved to be the wrong mix of personalities (two general practitioners and one ENT [ear, nose, and throat] man, former classmates). This dissolved and one other doctor carried it on in a disorganized manner for several years.

Hughes: Where did he get that idea?

Gumbiner: I have no idea where he got that idea. But he and three or four other people started a group practice, couldn't get along, so they all went their separate ways. It provided a pretty good illustration for me--that if you have a group practice, it may break up but you don't go your separate ways. Somebody has to hang in there and rebuild the group over and over again until you get it right.

Hughes: But he didn't do that?

Gumbiner: He didn't do that. He just went across the street and started a solo practice. In those days those doctors used to have solo practices tucked away in office buildings, like in bank buildings, and to my view their idea of marketing themselves was absolutely zero. Instead of being out in the neighborhood where the people were, they were all downtown. People had to come downtown, find a parking space, and drag themselves up to the

doctor's office on the sixth or seventh floor of the bank building.

The way doctors practiced in those days, at least around there, was probably exactly the opposite of the way they should have practiced. Of course they used to all get together and decide that anybody who did it any different than the conservative way was no good. He had sort of a neat formula: any doctor whose practice was bigger than his was running people through like cattle, and any doctor whose practice was smaller than his couldn't be much of a doctor. A nice, neat formula, right? When I grew up I figured there was something wrong with that.

Hughes: Well, he more or less proved that, didn't he? It doesn't sound to me as though he was flourishing.

Gumbiner: He wasn't flourishing. Of course, no one flourished in the early thirties when they had a big Depression on. Let's see, the war in Europe was in '39, so in about '36 countries were arming so they could have a war. The steel mill started to flourish in about '36, and my father had a heart attack around '35 or '36. After that he worked part time, and died when he was about forty-six. I think he died around '41 or '42.

Hughes: Do you think the hard work was a factor?

Gumbiner: No, no, he had mitral stenosis from rheumatic fever. I'm not too sure how hard these doctors worked. I think they just spent a long time in the office waiting for patients.

Hughes: Did he want you to go into medicine?

Gumbiner: Well, he had a rather unique way of putting it--he would pay my college expenses if I went to medical school; otherwise, he wouldn't pay them. He had another idea; it was that I should pay my own tuition. In high school I worked at labor jobs during the summer and saved up all my money (never spent any of it). With those savings I paid my own tuition when I went to college and he paid my room and board. I was very annoyed if the professors didn't show up, or if they cut out early, because I was paying them out of my fifty-cent-an-hour labor jobs. In retrospect, it was probably a good idea. I don't think it was a planned idea; it just happened that way.

Hughes: What was your mother like?

Gumbiner: She was just the standard housewife of those days, did the usual things--taking care of the kids and keeping the house.

Hughes: Did you feel close to her?

Gumbiner: No, not particularly. Didn't like her very much. [laughter]

Hughes: You're not one to beat around the bush. How about your father?

Gumbiner: Oh, I liked him all right, except he was an average hard-working middle-class person. I figured out by high school that he was a conservative Republican, probably on the wrong track. He was one of these people who did the same thing every Sunday. In the summer he'd play golf and in the winter he'd go bowling. He didn't have much imagination. He was a typical middle-class conservative doctor. We have plenty of them around today, doctors with very little imagination.

High School

Hughes: How did you get started on a different track?

Gumbiner: I guess when I was in high school. In those days a lot of us read pacifist books on World War I--Merchants of Death and Days of Our Years and things of that nature.

Hughes: A lot of people in your high school?

Gumbiner: Rather, a lot of people in my age group going to high school, before World War II and after World War I, were pacifists. We read a lot of books with a pacifistic bent and liberal bent.

Hughes: Do you think that was an interest of high school students at that time?

Gumbiner: I don't think so. You know how high school students are; there are a few intellectual types, a few athletic types, a few social types, and few types with no place.

Hughes: Where were you?

Gumbiner: I don't know. I had two or three letters in athletics and I was at the top of my class; I'd say I was in the intellectual/athletic group.

Hughes: Consisting of you alone? [laughs] I can't imagine there would be too many that would fit into such a group.

Gumbiner: Oh, there were several there. This was an advanced school system called the "Worth" system.

Hughes: What was that?

Gumbiner: It was an advanced school system that was designed for work, study, and play. It was a school system in which they taught speed reading in the first grade. I never learned to spell, but that's all right because secretaries do that, but I learned to read very fast.

Hughes: Were they using similar techniques to today's speed reading?

Gumbiner: You never sounded out the letters; you learned from flash cards with words. I don't know what the techniques are today. You learned to read whole paragraphs at once.

The idea was that the schools were open all hours of the day, seven days a week--that was the work, study, and play program. A third of the program was study, a third of it was some kind of shop or vocational activity, and a third of it was athletics. So the swimming pools, basketball/handball courts, and workshops were all open, with groups in attendance, for the evenings and all day Saturdays.

The reason the town had that program was because most parents worked in shifts. They worked eight-hour shifts so that every eight hours the town would light up; there would be the same number of people at noon on the streets as there were at midnight. When the shift would change, a third of the town would get up and go to work, a third of the town would come home at eight o'clock, and then another third would go to work for the next shift.

Hughes: And the kids were doing something similar?

Gumbiner: No, the idea was to keep them off the streets. In other words, we didn't have any "latchkey" kids because the school went on from eight a.m. until ten p.m. They taught classes in the evening, so you could take shop or a swimming class in the evening, or you could even take an academic class which was usually an elective. So, the school did not stop at four p.m., and the cafeteria ran suppers just like they ran lunches.

Hughes: Was the program subsidized?

Gumbiner: Yes, the city subsidized it. It was two different programs: there was a work/study/play program, which kept the kids in school for a longer day (like from eight a.m. to eight p.m. and

all day Saturday), and there was the advanced system of teaching in which you speed read and took a pretty advanced curriculum. In fact, when I went to Indiana University I didn't learn anything my first year that I hadn't already learned in high school.

Hughes: Was that speed reading course intended for college-oriented children?

Gumbiner: No, not particularly; it was for everybody.

Brothers

Hughes: Do you have brothers and sisters?

Gumbiner: Yes, I have two brothers. Mark Twain Gumbiner is about four or five years younger than I was, and Richard was about twelve years younger than I was.

Hughes: Quite a gap.

Gumbiner: I didn't really associate much with them because of the age gap, and I was away at school most of the time.

Hughes: What are they doing now?

Gumbiner: Well, one of them, Mark, finished his Ph.D. in anthropology at the University of Chicago and then went into the real estate business, which is very similar. [laughter] The other one died at an early age. The brother with the real estate business is out in Orange County.

Hughes: Is it chance that you both ended up in the same part of the country?

Gumbiner: He did his undergraduate work at the University of Chicago and Cal State San Francisco and then went to graduate school in Seattle, Washington. Then he came out here because I was out here and, I guess, he liked the weather. He lived in Mexico for a few years before that.

Hughes: Do you see him?

Gumbiner: I see him periodically.

Hughes: Give me a flavor of what it was like growing up in your family.

Gumbiner: Well, I can't give you a flavor.

Hughes: Sure you can; you were there.

Gumbiner: It was too long ago. [laughter]

Hughes: No, now come on, start thinking back. Describe a typical day and what went on.

Gumbiner: When?

Hughes: When you were in school. I'm trying to get at the family dynamics.

Gumbiner: I would race to school because I was always late.

Hughes: That pattern continued.

Gumbiner: Yes, that's right. [laughter] I was always trying to get too much done.

Hughes: Did you have much of a social life?

Gumbiner: Yes, I had some social life but it wasn't really exciting.

Undergraduate and Medical Student, Indiana University, 1941-1948

Gumbiner: When I went to college it was in the middle of World War II (that was September of 1941), and then in December the Japanese bombed Pearl Harbor. After that, people kept disappearing very quickly into the armed forces. Just the male population that was pre-med, pre-dental, 4F, or under eighteen was left behind.

Hughes: So, pre-med was relatively safe because they wanted you to finish medical school.

Gumbiner: Well, actually that was not the point. I went to pre-med before there was a war or a draft. After the war started, all pre-meds volunteered for the service, and the armed forces assigned us to college in the speed-up program.

Hughes: Once you were in medical school?

Gumbiner: No, undergraduate. We took our undergraduate work all year 'round and then followed with four years of medical school in

three calendar years. So, within five calendar years you were in your internship.

Hughes: Did you get enough education?

Gumbiner: We had exactly the same courses and didactic work. It was just compressed--three semesters into one calendar year--by eliminating summer, Christmas, and spring vacations. Only about half of what they teach in medical school is of any use whatsoever, and the other half of it is totally useless.

Hughes: But at that point, you didn't know which half was useless.

Gumbiner: No, you know which half is useless; anything where you had to memorize things, because the half-life of memory is a couple of years at the most. No one ever remembers all those nerves going through all the little holes in your skull. I have no idea of what use that was.

Hughes: But you learned it?

Gumbiner: Yes, you had to learn it. It was useless and you forgot it as soon as you learned it.

That leads me around to the opinion that there's no need for students to take summer vacations since we're not an agrarian society any more and we don't have to go home and get the crops in. Probably their time should have been used for students to go out and get in touch with humanity in the mills, in the mines, and on the farms, or anything to get them out of the academic environment. They should send the professors out there periodically.

Hughes: [laughter] Get them in touch with the real world, you mean?

Gumbiner: Well, you can go work in a factory for six months and find out how people have to live.

Hughes: Not a bad idea.

Gumbiner: After the war was over we had a free summer or two. One summer I did construction work in high buildings. I was a laborer and hob carrier. Another summer I hitchhiked out to Kansas and worked on the farms driving tractors and shoveling wheat, all of which I thought was a valuable part of my education.

Hughes: Tell me a little bit more about medical school. Was there any professor that you felt was particularly valuable?

Gumbiner: I had a pretty good professor in physiology--I don't remember his name--and a very bad professor in anatomy. I do remember his name. [laughter] I also had a few professors that weren't doctors that were trying to get back at the medical students. Indiana University at that time was not a very inspiring school. I didn't have anything to compare it with to know that it wasn't a very good medical school, to tell you the truth, but I felt it was not.

Hughes: Why did you go there?

Gumbiner: Well, in the first place I didn't have a whole lot of choice; the army sent me there. I was from Indiana, my father was a doctor, and I was looking at Indiana University because it was a state school and I could afford it. As I say, I was there only about two or three months and then war was declared. They gave me two choices: go into the infantry as a private, or sign this piece of paper and continue in pre-med under the army's auspices.

Hughes: That was not too difficult a decision.

Gumbiner: It was not a decision at all. [laughter]

Hughes: How were you feeling about the war in light of your pacifism?

Gumbiner: It was interesting. I can remember the day the Japanese bombed Pearl Harbor, on a Sunday. I was living in a dormitory and we all came down into the dormitory lounge. Everybody said they were not going to go get shot so that the military-industrial complex could make money. They were all going to hide out in Brown County, and they were going to do this or that.

But within about six months, they were all in the service because of the intense public pressure. It was not like Vietnam where people would go to Canada because the public wasn't necessarily putting pressure on them to go fight in the Vietnam War. World War II was a reasonably popular war and everybody was out to stop Hitler.

Hughes: Then there was also the fear of invasion, particularly on the West Coast which, of course, we never had with Vietnam.

Gumbiner: Well, I wasn't on the West Coast. They weren't about to invade Indiana. But nevertheless it was a reasonably popular war--make the world safe for democracy and all that.

Hughes: Did you get swayed by that philosophy?

Gumbiner: No, I was very happy to stay in medical school because I didn't believe war and killing ever solved anything.

Hughes: What did you do when the war was over?

Gumbiner: Well, in those days I was just like any other young person. If you ask the average young person what they would like to be doing in ten years, their eyes glaze over and they have no idea what they want to be doing in ten years or twenty years. In those days you just thought about staying in school so you didn't have to become a casualty replacement in the infantry. When you got out of school, you thought about the next step: where do you go for your internship, do you want to go into residency, or do you think you want to get married? Like most people, you don't actually think too far ahead.

Internship, Indianapolis City Hospital, 1948-1949

Hughes: Where did you intern?

Gumbiner: I interned at Indianapolis City Hospital. At that time it was a big charity hospital on the campus of the medical school.

Hughes: Why did you go there?

Gumbiner: I had several offers for internship. I was familiar with this hospital and knew it had a good internship program. It would give me a lot of practical experience because it was a charity hospital and it was also associated with the medical school campus. It was a matter of elimination. I eliminated the private hospitals because you don't get much experience. I eliminated the pure university hospitals because you didn't get any experience; they were too academic. I eliminated the pure charity hospitals that were not hooked up with a medical school because you just worked and didn't get any teaching. It was a matter of converting the unknown to the known.

I was somewhat bored with Indianapolis, never liked it very much in those days, but I understand it's come a long way since then. I had come from the Chicago area, which was more sophisticated. Gary was to Chicago like Long Beach is to Los Angeles--forty-five minutes away. I felt that Indianapolis was very parochial.

Hughes: Had you taken advantage of some of Chicago's offerings?

Gumbiner: Oh yes. I used to go to all the theater I could get into; I saved enough money to get in the door. I went to restaurants, night clubs, concerts, et cetera.

Hughes: How did you develop those interests?

Gumbiner: That's a good question; I have no idea. My father and mother were both from Chicago and would go to the theater occasionally, good restaurants, and night clubs in Chicago.

Hughes: There wasn't as much of that in Indianapolis?

Gumbiner: There was very little activity in Indianapolis. [laughter]

Hughes: Did the internship turn out to be a good one?

Gumbiner: Yes, it was about what I expected--a certain amount of experience and a certain amount of teaching.

##

Hughes: Did you get any ideas about what specialty you wanted to practice?

Gumbiner: No. I had no idea. [chuckles]

Hughes: So what did you do?

Gumbiner: What did I do? I knew one fact: I had no money whatsoever. I worked in the Indiana City Hospital lab when I was a medical student for my room, board, and laundry.

Hughes: To support yourself?

Gumbiner: I had the G.I. Bill after being in the army, so I had sixty dollars a month, which eventually I saved up for a car. Then I didn't have enough money for the gas, so I made arrangements to come up to Chicago with four or five medical students or interns who lived or had grown up in Chicago. They would each give me two dollars and then I'd have six dollars with which I could just make it to Chicago (I got gas for fourteen cents a gallon) and back again.

Hughes: You were living in the hospital?

Gumbiner: I was living in the hospital.

Hughes: So you didn't have any expenses.

Gumbiner: All my socks were purple because the hospital washed all the socks together--brown, blue, and black. [laughter] So if you got smart, you washed your own socks and underwear so you didn't have purple underwear and socks. We wore hospital whites, which the hospital laundered for us. All you really needed was one suit, one white shirt, one tie, one pair of socks that weren't purple, a pair of dark shoes, a pair of white buck shoes, and the hospital whites.

Since my internship was one of the old rotating internships, the first month we were in the emergency room for thirty straight days, twelve hours a day, which really was more like fifteen hours. You rode the ambulances and you usually didn't come back until you picked three or four people. Then you got out of the ambulance and sewed them up yourself, reduced their fractures, and whatever you did to them.

Hughes: Three or four people, regardless of their medical condition?

Gumbiner: No, you had a radio control that told you to pick this guy up.

Hughes: I thought you were picking three or four before you went back to the hospital?

Gumbiner: Sometimes you did. They'd say, "Now, instead of coming back, come over here and pick this guy up." We just picked up the stab wounds and bandaged them up a little bit, dug this guy out of the canal, got a man with a heart attack. We had these double-deck stretchers we'd put them in, and if somebody was dead, we'd stop at the mortuary and let him off.

Hughes: Was your training adequate?

Gumbiner: That was how you learned, by experience. Of course it wasn't always that busy. Sometimes we would go out and only pick up one heart attack.

Hughes: You were supposed to come to the internship with some medical knowledge.

Gumbiner: You had the residents there and the medical school teaching staff.

Hughes: But they weren't in the ambulance.

Gumbiner: Well, we brought the people back to the hospital.

Hughes: But presumably you had to do something en route if somebody was bleeding?

Gumbiner: Oh yes, we patched them up a little bit and started fluids. We could get back in five to ten minutes. Most things were not that bad.

Hughes: Did you take this in your stride?

Gumbiner: Oh yes, that was the way it worked.

The second rotation was obstetrics, where you would be on twenty-four hours delivering premis. Then the next day you'd be on twenty-four hours delivering people that went into labor while the first-up intern was delivering somebody else. You actually slept on the OB [obstetrics] ward. You had double-deck beds between the six delivery rooms.

Hughes: Just one intern?

Gumbiner: Two or three of us. You'd slip on your shoes and one person would give the mother the anesthesia and the other person would deliver. Then you'd take the baby to the nursery, put the mother on the gurney, and wheel her down. Meanwhile, you'd do all your own blood work and lab work and run your prenatal/postpartum clinics. The third day you were outdoor OB, where you went out to deliver the women in their homes. Then you got one evening off every three days.

We had another service called "outdoor doctor," or something like that. One intern would have the southern part of Indianapolis and one would have the northern part. They would give you a car, a bag, and you would run around treating people in the home.

Hughes: For anything?

Gumbiner: Yes, for anything they had. It was actually a community medicine service and we didn't know it--we didn't call it that.

Hughes: Do you know the history of that service?

Gumbiner: No, I don't know what happened to it.

Hughes: Was there any charge for the community medicine?

Gumbiner: No, no, this was a charity hospital. It was down in the really deep, dark, tough ghetto. There was always a sort of unwritten agreement in those days that nobody messed with the doctors in the hospital. All these people would have to come into the hospital to get health care for their kids or themselves when they were shot up. See, they wanted their doctors to take good

care of them, so they never messed with the doctors. We could walk around anyplace in our whites and no one would bother us. I came out one day and someone had stolen the headlights out of the car. [laughter] Another guy's car was jacked up; they stole all four wheels right in front of the hospital.

Hughes: So it was a tough neighborhood?

Gumbiner: Oh yes. They gave us fifteen dollars a month as interns. The food was so bad. For instance, on Tuesdays they used to serve steamed vertebrae.

Hughes: No.

Gumbiner: That's right, steamed vertebrae. It was steamed so long that all the little bits of meat fell off, so they would take this big spoon and throw the bones on your plate. On Wednesdays you had baked beef heart, and then on Thursdays you had sausage, which was guaranteed to have no protein in it. So, you practically lived on vanilla ice cream, which they made there.

There was a revolt when I was there. In December, toward the end of the budget year, some of the guys got mad because they had had six days of sausage and squash. That's all they had, sausage and squash and squash and sausage. So, they threw the sausage and squash against the ceiling of the dining room and caused a riot. The hospital administration told them, "We'll pay you more and you can buy your food anyplace." They then paid us seventy-five dollars a month, but no food. Since we were in this ghetto, and most of us were unmarried at that time, we had no place to go to eat. We had to eat in the hospital cafeteria, eating the sausage and squash, but now we had to pay for it! [laughter] So, we ended up with less than fifteen dollars a month.

Hughes: Were you learning much from the residents?

Gumbiner: Yes.

Hughes: They really were available and supervising?

Gumbiner: Oh yes, they were around and they were being supervised by the professors in the medical school. This hospital was part of the medical school.

Hughes: Did you have much contact with the professors?

Gumbiner: Yes, they would give some didactic lectures. Every Thursday we would have a session and would make grand rounds with them.

Hughes: Did you like that part?

Gumbiner: It was all right. Most of the attractiveness of that type of residency is that you got to do the work yourself. I did extra things. I didn't have room for an ENT rotation, so I'd come down on Saturdays and in the evenings and work in the ENT department. In those days they wouldn't teach you anything about birth control; it was against the rules.

Hughes: Against the rules of the hospital?

Gumbiner: Yes. I wanted to learn how to fit diaphragms and things like that, so I went to the neighborhood free clinic and helped out the doctor in charge. It was up to you to learn extra things that you wanted to know, but they were available.

Hughes: What does that have to do with ENT?

Gumbiner: Well, they're both orifices. [laughter] It has nothing to do with ENT!

Hughes: That did seem to be rather a fast leap there. [laughter]

Gumbiner: No, I didn't fit any diaphragms in ENT. It was against the rules. The only connection there is, in that hospital you had a lot of different services. You couldn't cram them into one internship year, so if you were energetic and wanted to learn, you did some extra work. Once in a while you'd get on a service, like psychiatry, where you didn't have to work thirty straight days and nights, like you did on some other services.

I was on orthopedic service and one day I had to set ten broken wrists. What happened was, they had a rainstorm and everybody had these little one-story houses that had a porch and a step. They'd come out on the porch, step down on the step, slip on the ice, and they'd fall down and break their wrist. We had a gurney with a fluoroscope under it and we'd fluoro their fracture and see where it was. (We had to wear a lead apron.) We'd have a big 20 cc syringe full of pentothal clamped to the gurney and we'd just change the needle on the tube and give them a squirt of pentothal, reduce the fracture, and put a hairpin splint on it.

We were the anesthesiologist, the orthopedic surgeon, everything. We even rolled up our own plaster bandages because we didn't have plaster pre-rolled. As I said, we would reduce the fracture, put a hairpin splint on there, wheel them off, and then bring in the next person. So, I don't have too much sympathy for people who tell me they have to have the finest new

equipment in order to get anything done, or that they are working too hard.

Hughes: How many different specialties did you sample?

Gumbiner: Rotate through? Well, you had medicine for two months, surgery for two months, orthopedics one month, psychiatry one month, and pediatrics one month. So, you'd get about six, or seven, or eight maybe.

Hughes: And some of those were mandatory?

Gumbiner: Yes. Your mandatory ones probably were medicine, surgery, pediatrics, and obstetrics. That would that you about eight months, so you'd have four more months to take, say, four one-month rotations. Well, you couldn't take them all so, if you took GU you wouldn't get ENT. If you took psychiatry you couldn't get dermatology.

Hughes: Did you like any of these specialties more than others?

Gumbiner: I wasn't too interested in anything particular; it didn't bother me. Actually, I got interested in public health later on.

Hughes: Why?

Gumbiner: It seemed to me that in public health you could do more good for more people than just seeing one person at a time. You could prevent people from getting diseases, and it seemed to me that would be more constructive than treating one by one as they got the disease.

Hughes: Where did you get exposed to public health?

Gumbiner: I don't recall where I got exposed to it, but after I came out here to California, I got a job in the public health department.

Hughes: Don't go quite that fast. I asked you, I know. [laughter]

Gumbiner: When you ask me, I tell you. [laughter]

Hughes: Did you do a residency?

Gumbiner: I did part of a residency by accident.

Hughes: You got your M.D. in 1948, so this must have been 1949.

Gumbiner: Yes. I got done with my internship in 1949 and had a little bit of money, about \$1,200.

Hughes: That you saved from this lab work?

Gumbiner: No, that I got from falling down the elevator shaft at a party.

Hughes: You better explain.

Gumbiner: Well, I was at this party in a hotel and I was walking out to the parking lot to my car. Somebody had left the cover off the loading elevator that went down two stories to the sub-basement. It was in a dark corner, I was looking for my car, and I stepped off into space.

Hughes: What happened to you?

Gumbiner: Well, I didn't stay up in the air. I went down--I hadn't learned to fly yet.

Hughes: Well, that part I sort of gathered. [laughter]

Gumbiner: I hit the bottom and tore up my suit a little bit, and I broke a little tuberosity in my knee. They hauled me into the emergency room at City Hospital where I was an intern. Then they called an orthopedic surgeon who tried to talk me into surgery on my knee. I was young but I wasn't stupid, and I told him I wasn't going to do that. I've never had any problem with this knee. He was trying to talk me into unnecessary surgery, which was my first lesson in unnecessary surgery. I made a settlement with this hotel and they gave me \$1,200 for my pain and suffering after falling down an elevator shaft.

Short-Term Jobs

Gumbiner: So, I had that money and I had this car. By that time I had been married about six months, and I decided I would get the highest-paid job I could find, save up my money, and come to the West Coast. I had hitchhiked out here before and I liked it pretty well.

Hughes: When had you hitchhiked?

Gumbiner: Oh, I had this one summer off after the war was over and I hitchhiked to the East Coast and I hitchhiked to the West Coast. In between, I worked in the wheat fields of in Kansas when I hitchhiked to the East Coast. I went to the theater every day for five days, matinee and evening, and then I'd hitchhike back west to the wheat fields and work there. When I would get into

the farmlands I would put on denims and a workshirt to hitchhike, and when I got to a city I would put the denims and workshirt away and put on gray flannel, a white button-down [shirt] with a tie, and a sport coat. [chuckles]

Hughes: And you'd get picked up right away?

Gumbiner: It was my first lesson in imagery. You'd never get picked up wearing a white shirt and blazer in the farmlands; you had to have on denims and then some guy would give you a job. He'd pick you up and say, "Looking for work?" "Yeah." "Okay, you drive a tractor?" "Yeah, I can drive a tractor." He would take you home and say, "Share the bedroom with my son." I'd work there for a week or two and when I was done he might say, "What's your name? I'll pay you off."

You were asking me how I entered residency? I came out here--

Hughes: Because you liked it?

Gumbiner: No, I had a job in West Virginia as a doctor for a prepaid practice in the coal mines where they had this check-off system. The union in those days, I think it was the CIO [Congress of Industrial Organizations], had these miners' clinics set up by the unions and prepaid through an employee/employer deduction called the "check-off. They had medical clinics and there was a prepayment plan.

Hughes: What does check-off mean?

Gumbiner: That means they would check off so much of each miner's salary for their health and welfare. I suppose even in the early days, I was open to systems other than fee-for-service.

Hughes: So prepayment.

Gumbiner: Yes, prepayment. My wife and I drove around and looked at different places. Down in Texas some doctor had this colored waiting room and a white waiting room. My wife started asking him why he'd do something like that. The guy took me aside and said, "You know, you'd be all right here, but you'd have to do something about that wife of yours; you can't talk like that around here."

Hughes: This was after you'd been involved with this check-off system?

Gumbiner: No, I hadn't been involved yet.

Down in West Virginia, in some little valley down there, I found a doctor that needed an assistant. He was running this check-off system, a prepayment system for outpatient care. Then the miners had the miners' hospital where they would go for their hospital care. I got a job with him and went back and loaded up my car with all my few possessions. Just as I was about to leave, I got a telegram saying that the mines had struck. There was no job.

So, I went back to Indianapolis, back to City Hospital, to see if anybody knew of anybody or anything. There were no jobs. I went all over Gary and there were no jobs for doctors. The mills were done hiring doctors and no doctors wanted an assistant. This was in about 49.

Hughes: I thought in general that was a fairly prosperous time.

Gumbiner: No, it was a bad depression. It was before there was any kind of health and accident insurance or Medicare insurance, remember that. When I came out here in 50, the Douglas plant, where they were making Willie jeeps in part of it, was closed. In 49 and 50 times were not good. You've got to remember, before the advent of health insurance doctors didn't make much money. In 1950 the average wage of a doctor was around \$5,000 to \$6,000 a year.

Hughes: Compared to what? What would a corporation president be making?

Gumbiner: Well, quite a bit more than that. Perhaps you could put it into context and compare it to what you could buy a house for. I bought a three-bedroom, two-bath tract home for around \$14,000, for which I paid \$67.50 a month, including taxes and insurance. The significant point is that if you were to take an average of 5 percent inflation per year for the last over forty years (1950 to 1990), that would amount to 200 percent. That times the \$5,000 doctors' annual income in 1950 which compounded would be, say, 300 percent. Well, 300 percent times \$5,000 in 1950 in doctors' annual income would be equal to \$30,000 per year in 1990's income. Today doctors are making much more than \$30,000 to \$40,000. So inflation in health care is significantly greater than the 5 percent inflation that we've had, on an average, on other goods and services. That's the point.

General Practice, Terre Haute, Indiana, 1948

- Gumbiner: So anyway, I got a job with a doctor in Terre Haute, Indiana, who must be dead now because he was probably about fifty then.
- Hughes: How did you get that job?
- Gumbiner: I got that job because somebody in Indianapolis told me there was somebody looking for an assistant in Terre Haute. I needed the money and the job, so I went out there. This doctor was doing everything wrong--crazy things.
- Hughes: Like what?
- Gumbiner: He was a ghost surgeon.
- Hughes: What does that mean?
- Gumbiner: That's when the general practitioner schedules somebody for surgery and puts his name down as the surgeon, but who has a qualified surgeon do the surgery. The surgeon acts as the assistant but he, in essence, does the surgery. The general practitioner gets the fee and pays the surgeon the assistant's fee.
- Hughes: Why would the surgeon agree to that?
- Gumbiner: Why? Hungry, he needed to eat. If there was a new, young, board-certified surgeon in town who didn't have a practice, he would scrub with this guy. This general practitioner would make the incision and then the surgeon would say, "Just a minute here, let me help you out." Then he'd do the surgery, the general practitioner would close [the incision], and he'd charge him for the surgery. No one knew about the ghost surgeon; they assumed that the general practitioner did the surgery.

The general practitioner split fees--he was a businessman. For instance, penicillin cost us three dollars an ampule in those days and he'd give people a shot for a dollar. He'd say, "Don't worry, in the winter we'll make it up in volume." In the winter he'd be doing unnecessary surgery on everybody who walked in the door. In other words, the penicillin was cost leader for expensive procedures.

He said, "Do you know how to read EKGs [electrocardiograms]?" I said, "Well, I know something about them." "Fine, we'll buy an EKG machine and you go out and take EKGs." I said, "Wait a minute; I'm not a cardiologist." "Do it

anyhow." So, I made house calls all the time in Terre Haute and Clinton. I would hook up the EKG machine, go out and put a stake in the ground outside the window, run the wire out, and when I went to plug in the EKG machine, no electricity. [laughter] I had the patient all hooked up and I assumed there would be a wall plug, but there was no wall plug.

I was with three general practitioners for about three months and that was more than I could tolerate.

Hughes: Did these patients have any need for an EKG?

Gumbiner: Who knows? Probably not.

Hughes: This was a way of making money and impressing patients with new technology?

Gumbiner: I guess.

Hughes: Did you talk to him about his ethical practice?

Gumbiner: Oh, he wouldn't talk. He had his office in his house and there were no appointments--everybody just came in and waited. On my first day with him, the nurse said, "We have a new doctor; anybody like to see the new doctor?" Several people stood up. I think that made him very upset. He came over to me and said, "I tell you what you do. I'll take the history on these people and you do the physical." "How can I do the physical? I don't know what's wrong with them." He said, "That doesn't matter." [laughter]

One day we were doing an operation on some old lady with a gall bladder problem. We just had to open up the gall bladder and drain it. All of a sudden she stopped breathing. In those days the anesthesiologist was the oldest doctor in town who couldn't do anything else, so they gave old Charley the job of being the anesthesiologist. The patient had stopped breathing so the old guy said, "I'll take care of that." He pulled a rag out of his pocket, stuck it on the patient's face, pulled a bottle out of his inner pocket, and sprinkled its contents on the rag. Then he gave her chest a few pushes and, miraculously, she started breathing again. I said, "Wow, what's that? I never learned about that in medical school." He said, "It's spirits of ammonia." I said, "Do you have an anesthesiology machine?" He said, "No, I don't know how to use one." [laughter] So I left that practice.

Hughes: After how long?

Gumbiner: About three or four months, and then came to California.

Josephine Schlenck Gumbiner

Hughes: You've mentioned your wife, Josephine Gumbiner, but just in passing. How did you meet her?

Gumbiner: I was a senior in medical school. I had an aunt and uncle who had a daughter living in Minneapolis who was getting married. She had a reception after her wedding and it was sort of a command performance for me because I had been invited to enough dinners by my aunt when I was in medical school. So, I went there, sort of an obligatory thing. I put on my one suit and my one clean shirt and went over to the reception. I was standing around there with a bunch of people I didn't know and couldn't care less about, when I saw this good-looking little blonde standing there. This gal had been working with my cousin as a social worker. I went over and started chatting with her and that's how I met my future wife.

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Gumbiner: She had gotten a scholarship to the University of Chicago in social work administration and had gotten her bachelor's degree at Miami University in English. Her grandmother had gone there, her mother went there, her father went there, et cetera. There, she was what they call a "big woman on campus." She was in the honor society, she was editor of the school paper, BWOC Morton Board (society for high activity achievers). I thought she was sort of interesting. She had graduated third in a class of 1,000 people in high school.

I was intrigued because in college she got into a big fight with her sorority because of an editorial she had written against sorority rushing. She told them to forget it and resigned from her sorority. That caused a big furor.

Then she went to New York where she lived in Greenwich Village and got a job at the New York Post working for the labor editor. His name was Vic Roesege and he was always afraid the communists were going to get him, and finally somebody blinded him with acid. She quit working for him because she got a Doodle Scholarship to the University of Chicago. This was a \$75.00-a-month living allowance scholarship, plus tuition, and during that time she ate a lot of peanut butter sandwiches. She finished her masters degree in social work administration.

I was doing my internship in Indianapolis and her family lived in Indianapolis. She was in graduate school in Chicago and I lived around Chicago. That's why I was always driving up to Chicago with those people who were paying for the gas.

Hughes: To see her?

Gumbiner: Yes. She had a third-floor walk-up apartment near North Side, between Michigan Boulevard and Rush streets, with great big windows in a peaked type of building. They didn't have any window coverings so the Lindberg Beacon on the Wrigley Tower would come in and light the place up about every thirty seconds.

After she finished graduate school, in the winter of 1948, we got married. We were married during the last half of my internship and then we came out to the West Coast after working in Terre Haute for a few months. So, how did we get to Long Beach? Well, it was about November when we arrived in northern California and it was cold. We decided instead of going north, we'd go south. So, with her graduate degree we went south until she found a job for \$250 a month in Long Beach as a social worker.

Residency, Orange County Hospital and Farm, California, Spring, 1949

Gumbiner: I didn't have a California medical license, but I had to do something. In those days they only gave licenses quarterly and I could get one through reciprocity with my Indiana license. I got a pediatric residency in Orange County with what was called the Orange County Hospital and Farm.

Hughes: What's the "and Farm?"

Gumbiner: It was a hospital and poor farm. Some people, when they weren't in bed, were out there hoeing the turnips.

Hughes: So it really was a farm?

Gumbiner: Right out here in Santa Ana. It's now the University of California Medical School Hospital.

Hughes: You could practice there without a license because you were a resident?

Gumbiner: In those days, and I don't know if it's true now, you could be in the Veterans Administration as a doctor or you could practice as a resident without a license. So I got a residency in pediatrics there for about three or four months.

Hughes: But only as an expediency?

Gumbiner: Yes. I didn't want to spend my career in pediatrics.

Hughes: Well, you didn't really want a residency either, did you?

Gumbiner: No, I didn't. They offered me a residency in internal medicine at Harbor General Hospital or a pediatric residency in Orange County. For some reason I took Orange County, I suppose because everybody spoke Spanish there and they only had Mexican food for breakfast, lunch, and dinner. I thought that was sort of exotic.

Hughes: Did you speak any Spanish?

Gumbiner: No, but I learned pretty fast. Quitase sus pantalones, por favor (Take off your pants, please)--I learned that. [laughter]

As soon as I got my license I decided to do something else, particularly since the hospital was collapsing. The internal medicine resident quit so they made me the pediatric resident and the internal medicine resident. When the psychiatry resident quit, then they wanted me to be the psychiatry resident, the internal medicine resident, and the pediatric resident. Well, I did that for a while and then somebody else quit and I said, "Forget it, I'm not going to be four residents."

Hughes: Why were all these people quitting?

Gumbiner: I don't know. Maybe they didn't like Mexican food. [laughter]

Hughes: Could have been something wrong with the hospital.

Gumbiner: Could have been something wrong with the hospital. They had lousy attending doctors. I didn't think they were doing things right. I got in an argument with the head of psychiatry, who wanted to give psychiatric patients morphine, which was absolutely taboo in my internship. They were just producing a poor quality of medicine and I didn't want any part of it. They would give them morphine and then they could become addicted. There were just a lot of bad doctors.

I met a lot of bad doctors in my "externship" in the hospital in Gary. After I came back from one of my hitchhiking trips, I didn't have any food or lodging so I checked into the hospital as an extern in medicine for a month or so between my junior and senior year. Boy, there were some bad people there too. They came in drunk to operate and so forth.

Hughes: Seems to me you were getting a rather cynical view of medicine.

Gumbiner: You have to be in it to know it.

II EARLY CAREER

Public Health Work in Orange County, 1949-1950

- Hughes: Did you ever think of getting out of medicine entirely?
- Gumbiner: No, I thought about going into public health and reforming it. So I went into public health and--
- Hughes: In Orange County?
- Gumbiner: No, in Long Beach. Then I found out about public health.
- Hughes: What did you find out about public health?
- Gumbiner: I found out that the doctors who worked in public health at that time didn't work very hard. They were not very ambitious and a lot of them were retired in place. I'm not familiar with public health in general, but a local public health office is very political. Usually the public health officer is appointed, so he does what he's told and doesn't rock the boat. Being a boat rocker myself, I didn't last long in public health.
- Hughes: Appointed by whom? The mayor?
- Gumbiner: I don't know exactly how it worked, but in a city he's usually appointed by the mayor or some commission. Public health is pretty political and pretty slow-moving in general.
- Hughes: But there is a good dose of preventive medicine, which I think would have appealed to you.
- Gumbiner: It was pretty routine and not very innovative or effective. I was supposed to be the contagious disease officer, assisting the public health officer.

Hughes: Did you know something about contagious disease?

Gumbiner: Oh yes, I knew something about it.

Hughes: Where did you pick that up?

Gumbiner: Well, I learned it as an intern at Indianapolis City Hospital where there was a service called community medicine, where you could have twenty cases of measles in one day, among other things.

I'll give you an example: as part of my job I was in charge of a program to teach restaurant workers correct food handling. It was called the Food Handlers' Educational Program. So, I said to the public health officer, "I think we should make this program compulsory." I had just gone through the records and found that the same restaurants sent their employees over and over again to do this voluntary food handlers' program and they were only from about 20 percent of the restaurants. Furthermore, the restaurants that sent their employees to the voluntary food handlers' program were all the good restaurants that were well-run. The sloppy-joe, crummy restaurants that were terrible and that really need this program never sent anybody to the food handlers' course.

I said, "We're going to have to change this and make the course compulsory." The public health officer said, "Never. We can't do that because of political problems. We can only have it voluntary." I said "Oh, I can't put up with that; it is a waste and not accomplishing what we want to do."

I was running the VD [venereal disease] clinic in the morning. It used to take my predecessor all morning to run the VD clinic. Being sort of hyperactive, I would get the VD done in two hours. Then I'd run the well-baby clinic. I had run well-baby clinics during my pediatric residency.

Since I didn't like to spend too much time eating, I'd run the well-baby clinic at the lunch hour and I'd be done with everything they could possibly give me to do by about two o'clock in the afternoon. That didn't make the public health people very happy because now they didn't need all those employees all of that time.

Then I said, "Well, what should I do? Well, I'll learn something about public health." I read some books and I said, "I'll go out with the food inspectors." I'd say, "Well, let's inspect this restaurant." I was told, "Oh no, we don't want to do that." We'd go into another restaurant, inspect it, and have

lunch. The guy would go to pay his bill and the proprietor would say, "You don't pay your bill here; what are you doing?" We'd then go into a market to inspect it and the proprietor would say, "Oh, I've got your tenderloins and hams for you." The inspector would say, "Shut up." Then I'd say, "Let's inspect that flophouse over there, that looks pretty bad." The inspector would say, "Oh no, we don't inspect that one. We'll inspect this good one over here."

The next thing I heard, the health inspector, my boss, called me in and said, "I want you to stop going out with the food handlers and hounding the inspectors. You're causing trouble."

When I was in charge of the venereal disease program, I had this guy I inherited who was supposed to be the investigator of VD contacts. He was never around during the day, so I said, "I don't think you work. When do you work?" He said, "I work in the evenings." I said, "You work in the evenings?" He said, "Yes, I work in the evenings; I investigate VD cases." I said, "Is that right? Where do you investigate them?" He said, "I investigate the VD cases in the bars in the evening." [laughter] I said, "Wait a minute, I'll tell you what I'm going to do. You are my contagious disease investigator, so I'm going to have you help in the TB [tuberculosis] sector."

In those days we didn't have the medication to treat TB. We had to put people with tuberculosis in TB sanitariums until they got better, particularly if they had small kids at home. Well, the problem was, there was no mandatory law that said we could do that. So, unless the person volunteered, you couldn't do anything about it.

But I devised a system. I found a TB sanitarium at the end of a twenty-mile road in the middle of the desert in San Bernardino. To get out of there you had to walk twenty miles in the hot sun. I told this guy, "Tell you what you do. I've got some TB people that won't go to the sanitarium and they have small kids at home. I want you to get them in the car, tell them you're taking them out for an examination, and I want you to take them out to that place. While they're in there being examined, you leave, and there they will be. They can go home if they want, right, but they have to figure out how to do it." [laughter]

Hughes: Wrong.

Gumbiner: Anyway, the health officer didn't like that, so naturally they fired me.

- Hughes: Well, you were getting a reputation as a troublemaker, I would think.
- Gumbiner: I was too hyperactive for them, that was the problem; plus that public health department was doing a poor job when it could have been improved.
- Hughes: You really got fired?
- Gumbiner: No, the health officer called me, and we had a little chat and decided I should leave. [laughter]
- Hughes: What exactly was he complaining about?
- Gumbiner: He was complaining about me trying to remake the food handlers' program, working too fast, doing too much, sticking my nose in the food inspectors' and the housing inspectors' business, and various things that I was doing in general. I was trying to get things organized.
- Hughes: Well, you were not only hyperactive, you were exposing them.
- Gumbiner: Then I said, "Well, I'll do something else."

Reserve Officer, U.S. Air Force, 1950-1952

- Gumbiner: You have to remember at this time the Korean War was on. So, about the time I was in my residency they called me and said, "We're going to draft you; you're number one on our hit parade because you went through school at taxpayers' expense in the army and you never went into active duty. So, we're going to draft you unless you volunteer." I said, "Well, okay, but I don't want to go in the army this time; I'll go in the navy." So I went down and the navy said, "We've got all the doctors we need." I then walked across the street to the air force and they said, "Fine, we'll take you." So I signed up and became a first lieutenant in the air force reserve.
- Hughes: Why didn't you want to go into the army?
- Gumbiner: I didn't like the army.
- Hughes: How did you know?
- Gumbiner: I'd been in the army and in ROTC [Reserve Officers Training Corps] for years. I'd been in basic training and so forth. I

thought the air force would be more pleasant and you don't have to go marching around. You sit back at headquarters and you fly around, right? Better to fly around than walk around.
[laughter]

Hughes: Is that the way it turned out?

Gumbiner: I was never called up.

Hughes: Why?

Gumbiner: They just never got around to it. That's the way the armed forces operate; they have a whole bunch of people in the reserves (that's what reserves means). When they need you they call you up and if they don't need you, they don't call you up. There I was. I didn't know whether to start a practice or not because I didn't know if they would call me up, and they could have called me up any time they felt like it.

Physician at Ross-Loos Health Plan, 1950-1951

Gumbiner: I said, "Well, I'll try something else." So I tried prepaid medicine. In those days you had Kaiser and Ross-Loos as the early group practice prepayments, as I recall. I don't know if you know about Ross-Loos.

Hughes: I know the name, but I don't know much more than that.

Gumbiner: It was a organization started in the early thirties (during the Depression) by Dr. Ross and Dr. Loos. Their first contract was with the City of Los Angeles and, I believe, it was for the police and fire departments, or something like that.

They had a small office in San Pedro. I was living in Long Beach and San Pedro was about a half-hour drive away. So, I took over their San Pedro office and was the doctor there. I used to work very hard. Although I was working for a salary, I was a very progressive type. I got \$450 a month as a resident, \$550 in the health department, and \$600 from Ross-Loos, or something like that. I took over their office and I built it up until they needed two doctors--another doctor and myself.

Hughes: You attracted patients?

Gumbiner: The patients were on prepayment but they could go to any Ross-Loos office, and so if they liked a particular doctor they would go there. More and more of the people around San Pedro came in.

Ross-Loos had a very screwy setup. For instance, I would share house calls with the Long Beach office. One day I made three house calls and went 150 miles. They would not pay for your gas or the use of your automobile, plus you were supposed to collect two dollars for each house call and keep it, which was sort of stupid. It was embarrassing to charge two dollars, so I wouldn't charge anything. I would say I learned everything you should not do in prepayment from Ross-Loos. They did almost everything wrong.

Hughes: Was it a staff model health maintenance organization?

Gumbiner: Yes, it was a staff model.

Hughes: How did it work?

Gumbiner: It worked poorly. They paid doctors a salary and, theoretically, the doctors could collect 50 percent of their charged fee for any fee-for-service patient.

Hughes: You mean they kept 50 percent?

Gumbiner: Yes, they would get paid 50 percent of their charged fees for private patients but, of course, no private patients ever came in. As I say, their house call system was screwy. I had no x-ray or lab in this office; I just sent everything up to the Queen of Angeles Hospital. They would never tell me what happened to the patient or what they found out. It was just a terrible system, with zero management and zero support.

Hughes: So you were off doing your thing?

Gumbiner: I was off on my own, with a nurse. Once every month a supervising nurse would come around and see if we were still alive.

Hughes: Did you ever meet Ross or Loos?

Gumbiner: Not until they fired me. [laughter] No, I met Dr. Loos. They'd have a meeting every once in a while to get feedback, and I'd tell them what was wrong with the system. They didn't like that.

The end of that job came when some union leader slipped, who was an amputee. (He had a mid-thigh amputation.) He

slipped in a gas station, fell on his stump, and fractured his stump. He called me up and wanted me to make a house call. I had about four or five other house calls to make so I said, "Well, I can't do anything for you at home. You need an x-ray. I suggest you have somebody put you in the car and take you up to the hospital and get an x-ray of your stump and see if you have a fracture." He wanted me to come out to his house, which would have just delayed treatment, but I didn't think that was necessary. It ended up we had a big to-do about that. I didn't like the way Ross-Loos was running the program and I told them so.

One day someone called me up and said, "I'd like to know where I can get housing. I'm the new doctor taking over the Ross-Loos San Pedro office." I said, "That's nice. I wish someone would tell me since I'm working there." So, I left there and I went to an organization that did industrial medicine or workers' compensation.

Hughes: Did you see any virtue in prepayment?

Gumbiner: I saw the virtue that you didn't have to charge people for their health care services, and you could organize to benefit everyone if you went about it correctly.

Hughes: Were you beginning to think that this was something that you wanted to do?

Gumbiner: Oh, I didn't think about it too much. It was part of an education I was getting.

Physician at a Workers' Compensation Industrial Clinic, 1951-1952

Gumbiner: Then I went to another organization and just did workers' compensation [medicine].

Hughes: What was the organization?

Gumbiner: Hmm, I forget. It was over in Willmington, or someplace like that. I worked there six days a week and I made \$700 a month, a raise of \$50 a month. But we were driving all over the county on house calls. I learned a lot there, however. I learned to do ambulatory orthopedics and emergency care because they had a good orthopedic surgeon that worked there, in addition to some

older, experienced general practitioners. So I learned a lot about practical ambulatory care there.

Hughes: You were seeing some good medicine for a change?

Gumbiner: Yes, I learned how to handle a different type of patient and a volume. Since I had spent about a year in public health, about a year at Ross-Loos, and about a year in this workers' compensation industrial clinic, I would say I had some good on-the-job training during that period.

Hughes: Now this obviously is not conventional fee-for-service medicine. Were you merely trying to occupy yourself during the Korean War, or do you think regardless of the war situation you would have chosen these types of medicine?

Gumbiner: No, I probably wouldn't have done that. The first job I had was fee-for-service medicine in this little town.

Hughes: Yes, that's true. This is no ideology that you were following; it was just practicality.

Gumbiner: That's right. I was just getting a job.

Hughes: And a job that you could leave any time you wanted.

Gumbiner: I could walk away; I had no investment in it.

Solo General Practitioner, Private Practice, Lakewood,
California, 1952-1954

Gumbiner: After about a year of workers' compensation practice, I decided finally to go into private practice. I opened up a practice in Lakewood, California, which is part of Long Beach.

Hughes: Why there?

Gumbiner: Why there? Well, it was a brand-new community. They were building some big tract homes and I could get an office there. Some doctor wasn't doing too well. He figured it was the office, so he was moving to a big building in the shopping center and he was willing to rent me his old office for the term of his lease, as well as pick up half the lease cost for the last year of the term. It seemed like a pretty good financial deal because I didn't have any money, it was really inexpensive, and they were building a great big tract right within a mile of

there. So, I took over his office. We decorated a little bit and went to work.

Hughes: Did you take over his patients, too?

Gumbiner: No, he took his patients with him.

Hughes: So what did you do about attracting patients?

Gumbiner: What did I do? Well, I decided how to attract patients. [laughter] You walk around and you meet all the businessmen in that little business area. Then you check out all the construction jobs and offer to take care of the workers' accidents and so forth.

Hughes: You mean you walked into people's offices and said, "I'm the new doc in town and if you have problems, send your people to me"?

Gumbiner: Well, you've got to be more subtle than that. You walk into a business, you buy something, pay for it with a check with your name on it, and you introduce yourself. You find out who is doing the big industrial sites or the big supermarkets and introduce yourself there and say that you've got a new practice, you've had some experience in workers' compensation, and you would be happy to take care of their cases. You leave your card.

Hughes: And that method paid off?

Gumbiner: Then I decided that I'd send an announcement to all the people who moved in this new tract--just one of these standard announcements of the new doctor in the neighborhood: "So-and-so has opened a practice, office hours are such-and-such, telephone number is such-and-such." In those days there was a portion in the bylaws, or whatever it was, of the county medical association that said if you were in an isolated area, you could send out announcements that you were opening your office. It seemed to me that it was a public service to send out an announcement that you were a new doctor in the area and you were available to take care of general practice patients. So, I sent an announcement out to all the people in this new tract. The county medical association called me up promptly and asked me to come to their office and told me I was unethical.

Hughes: Because you were advertising?

Gumbiner: They alleged that I was advertising, but I was not. I told them, "Well, I don't agree with you there." Nothing happened. I just pointed out the chapter and verse that said if a doctor

was in an isolated area, he could send out one announcement of his practice opening.

Hughes: How did you know that? Had you checked it out?

Gumbiner: I checked it out.

Hughes: And they honestly didn't remember that part, or they didn't care to remember?

Gumbiner: They didn't bother; they were simply responding to someone who had complained, probably to the guy whose practice I took over. He was still not doing well and I was doing tremendously well because I kept evening hours, worked all day Saturdays, and had Sunday morning hours.

Hughes: Were you a member of the county medical association?

Gumbiner: Yes, I was a member.

Hughes: You were practicing standard fee-for-service medicine?

Gumbiner: Well, yes. I did a lot of other things; I'd go to the mental hospital at six in the morning and do physicals on the patients. Then I'd make my hospital rounds. I'd go to my office and instead of eating lunch I'd do the well-baby work for the city well-baby clinics. Then I'd come back and have my office hours and I'd take any doctors' calls off the exchange. Then for a while, in addition to that, I was the night doctor on call from midnight to eight in the morning for the McDonnell-Douglas Aircraft plant. Some of the activities were salary positions. It was a mixture, and I put in a sixteen-hour day.

Hughes: What do you mean, "Take any doctors' calls off the exchange"?

Gumbiner: In those days they had a doctors' exchange that took the doctors' telephone calls and got hold of the doctors. The patients would call up and say, "I'm looking for a doctor, any doctor." So the doctor who wanted take these "any doctors'" calls would put his name on the any doctor list. We'd take turns; you would be the doctor for a week and then somebody else would be the doctor.

Hughes: What if you got into things you really couldn't handle?

Gumbiner: What?

Hughes: Well, I don't know. I can't imagine that every doctor on the exchange could adequately handle every situation that came up.

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Gumbiner: Most of the calls were for minor problems. More serious cases I would admit to the hospital. For specialized care, I'd call in a specialist, for cardiac, ruptured peptic ulcer, and minor orthopedic cases. There wasn't too much that we referred unless it was general surgery or orthopedic work. Remember, the general practitioner was better trained and equipped in those days, and medicine was less sophisticated and complicated.

Hughes: Were you pretty much doing everything except surgery?

Gumbiner: Yes. See, I had worked in this industrial clinic where we did all our own eye work and all our own orthopedic work. In public health I'd made weekly dermatology rounds at the VA [Veterans Administration Hospital] and contagious disease rounds at the county hospital. I did a thirteen- or fourteen-week course in ENT to learn something more about that. I also took a course in pediatric orthopedics. I'd get the orthopedists around town to help me learn how to do closed fracture work, and then I'd help them on surgical cases, et cetera. I had taken a lot of extra evening services in my rotating internship, plus a lot of postgraduate work during the public health period, where there was a lot of extra time. In general, I'd taken many postgraduate courses from the several Los Angeles based medical schools and teaching hospitals when I was in general practice.

Hughes: And were you readily accepted by the locals?

Gumbiner: Oh yes, the local specialists (who have all the power) loved you when you were a referring fee-for-service general practitioner. When you start building a group practice, and start adding your own specialists, those community specialists don't love you any more.

Hughes: Well, that's a little later in your story.

Gumbiner: Okay. So, I was a general practitioner out there for about a year or two.

Hughes: Did you like this?

Gumbiner: No, it was terrible.

Hughes: Why?

Gumbiner: I remember one time I worked six weeks without one day off because there was a flu epidemic. You never got any time off. Even if you were to arrange with a couple of other general

practitioners to switch calls, they wouldn't always show up. You had to take your own calls.

One time there was a very popular Sunday professional football game and I had tickets, plus I wasn't on call. All of a sudden I got this call and I said, "Wait a minute, Dr. So-and-So's on call." "No, he left for the football game." So you had no control of these people. When you called them up and said, "What the hell are you doing, you went to the football game and I had to give up my tickets," they would say, "Oh, I wasn't on call that day, was I?" "Yeah, you were." [chuckles]

Hughes: It was too late by then anyway.

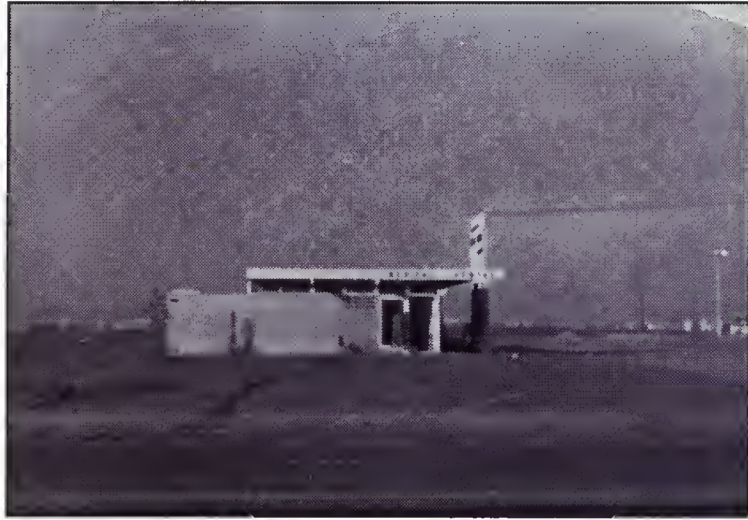
Gumbiner: Yes. So I found that didn't work too well.

Mother, Anna Bleiweiss Gumbiner, circa 1920.

Father, Benjamin Franklin Gumbiner, circa 1920.

Robert Gumbiner, two years old, 1925.





Above: Plaza Medical Center. Palo Verde and Spring Streets, Long Beach, California, 1958.

Below: Lakewood Professional Center, first office. Lakewood, California, circa 1953.



III THE LAKEWOOD PLAZA MEDICAL GROUP AND THE FAMILY HEALTH PROGRAM

Group Practice, Lakewood Plaza, Long Beach, California

Gumbiner: I decided after a year or two of solo practice that the only way was to develop a group practice. In order to do that I would have to have a building. So, I began exploring the area for possible sites.

Hughes: What was your motivation?

Gumbiner: Well, my motivation was to have a more organized life and to develop a more effective way to practice where you could get time off, you could get help on cases, you had people to consult with, you'd have your own x-ray and lab, and you'd hire your own lab and x-ray technician. Actually, you do a better job of delivering care if you don't have to take your own x-rays (with inadequate equipment), or send them someplace else and wait to find out what the problem is, and then have the patient come back. A solo practice without adequate staff and facilities is an inefficient, expensive, and wasteful way to practice.

Hughes: How common was group practice in this area?

Gumbiner: Well, it wasn't too common. There were a couple of groups around town at that time that had been here for a while.

Hughes: What did the county medical society think about group practice?

Gumbiner: Oh, I don't recall. I'm sure they weren't too happy with group because the county medical society reacts to its members. If they're solo practice, they don't like anybody who competes with them. That's the name of the game. I'm sure that the majority

of the members who were solo at that time didn't like group practice or anybody starting any competitive system.

I located a site in the Lakewood Plaza, in a large group of new homes which was to the east of where I had been practicing. A small shopping center was developing and everybody told me it was impossible to get a site to build a medical building there. I figured that probably was a good place to build a medical building--because everybody thought it was impossible.
[laughter]

Hughes: Sounds like you.

Gumbiner: I did a lot of research and found out who owned all four corners there. I found out that the Irvine Corporation Foundation owned one corner, but they wouldn't talk to me. I kept writing, calling them, and trying to get in touch with them.

Hughes: Were they deliberately avoiding you, or were they just too busy?

Gumbiner: Too busy to fool around with this little piece of land. The Irvine Corporation owned hundreds of thousands of acres out here. So I hired this young engineer to design my building and to try and get this piece of land. He was one of these guys that was unidimensional; he would just go through a block wall if you pointed him in that direction. He went out there, kept going out there, and finally to get rid of him, the Irvine Corporation decided they would lease me this piece of land.

Then I was faced with the problem of financing this land. I didn't have any money as I had only been in practice for about a year or two and had just bought a tract house in this Lakewood Plaza area on my G.I. Bill for six hundred dollars down and sixty-seven dollars a month (that wasn't too bad). Finally, I got a lease on the land. They would give me the first year free to let me build the building and then build that cost into the lifetime of the fifty-year lease going forward. Then I found out that I couldn't get a loan for a building that was on leased land.

Finally I went back to the Irvine Corporation and they told me, "We have a lending company; we'll lend you the money." So they loaned me part of the money and, I think, I had \$5,000 that I put down. I found a dentist who was in the navy and getting out in six months. We developed an idea that he would put up \$10,000, which would be prepaid rent, for which he'd get a rental discount over the next number of years. His prepaid rental, plus my money, went as a down payment. I was on leased land but I had the mortgage, plus the dentist's prepayment, and

I borrowed some family money from my wife's aunt. I had three or four loans and a lease.

I began building this building. The only problem was that when they designed it, they thought it was on city property, when it was really on county property, so they had to redesign it at the last minute. When I built it, the contract for the building was for \$27,000 but ended up with an additional \$7,000 in extra overages. I didn't know what to do about that. The selected contractor died in the middle of the construction so his son took over and he didn't know what he was doing. Anyway, we litigated about the extras.

The dentist moved in and then I hired another general practitioner and a general surgeon who did general practice.

Hughes: Were you partners?

Gumbiner: No, they were working for me on a salary and some percentage. The idea was that after a couple of years they would become partners, but the first two doctors didn't work out. While we were discussing a partnership with an attorney, behind my back they tried to set up practice down the street and take my patients. I fired them for this and sent out an announcement to all my patients. Then they split up because they couldn't get along. One of them went bankrupt, one became a psychiatrist, and the other one got divorced, took his pet monkey and drifted off. This was my first lesson in poor selection of employed doctors.

Then I brought in two more people, more experienced people. One was a general practitioner from Canada and one a general surgeon from this country. I thought this change would prove more successful.

Hughes: Why were they willing to join the group if they were older?

Gumbiner: They weren't that much older. They were probably five years older than I was.

Hughes: But even so, what was the motivation?

Gumbiner: Simple: they wanted to move to California. I'd pay them a salary, they would become familiar with my patients, make a list of patients' names, they'd quit, go down the street, and take the patients. It was a lot easier to do that with one young entrepreneur than with an established group. [laughter]

That happened the second time. These two guys plotted together, opened up a practice together, and then they split up. Probably the same elements that kept them from subordinating their desire for control did not allow them to work together.

So, I went back and tried it a third time. I recruited a pediatrician, a general surgeon, and a general practitioner. By this time I was beginning to understand the dynamics of recruiting. We lost the general surgeon to a residency in thoracic surgery but then the general practitioner and I began bringing in other doctors. Finally we got up to ten doctors, who were all partners. I had developed a system that after two years they could buy into the partnership for no money down.

Hughes: How were you getting these people?

Gumbiner: I recruited them by advertising in the Journal of the American Medical Association [JAMA] and various magazines.

Hughes: They worked for you until they became partners?

Gumbiner: They worked for the medical group where I was the senior partner. The first fellow would become a partner with me--we had partnership number one. The next person would work for partnership number one for two years and then we would form partnership number two, consisting of three doctors. Then the next person would work for partnership number two and after two years we would form partnership number three, and so on. We had a whole sequence of partnerships until we got to partnership number nine. What made this work was that there was no cash buy-in. Instead, as each new partnership was formed it would buy the accounts receivable from the previous partnership as they were collected. Thus, the partners in number one were receiving income from nine different accounts receivable, partners in number two from eight accounts receivable, etc. I developed this system from another local group practice.

Hughes: Were you being selective in whom you were allowing to enter this group?

Gumbiner: Oh yes, we were being very careful--that was the key.

Hughes: Careful about what?

Gumbiner: Well, mostly about the type of doctor the person was, and their personality.

Hughes: In terms of business or in terms of ethics?

- Gumbiner: No, they knew nothing about business and nothing about ethics. [laughter] They don't teach that in medical school.
- Hughes: Well, doctors should know some ethics from the way they're brought up.
- Gumbiner: What are you talking about? That is naivete. I had one doctor that was a very fine doctor, probably one of the finest internists I ever knew--a very straight-laced, ethical type of guy in medicine. Right in the middle of a contract he quit to go to work with another group because they offered him more money. I said, "Wait a minute, how can you ethically quit in the middle of this contract? At least you can work to the end of the year so we can find a replacement to take care of your patients." He said, "Oh, doctors don't have to bother with business ethics; we're ethical to our patients." This type of selective thinking is what I'm talking about.
- Hughes: So what were you looking for in a partner?
- Gumbiner: You looked for people who were flexible, who could get along with other people, who had some good communication skills, and who were not going to want to run the show themselves. You can't have ten partners, each one of them wanting to be the controlling person. Essentially I was looking for mature people, emotionally secure, with broad interests.
- Hughes: You wanted to be the leader?
- Gumbiner: It's a matter of practical policy: I'll lead and you follow, or you lead and I'll follow, but we can't have a general partnership where all the partners want to be the leader.
- Hughes: How much following have you done?
- Gumbiner: Following? When I have to--if the situation calls for it, or the individual has special knowledge or respect. But I've seldom found anybody to follow.
- Hughes: That's what I figured. [laughter]
- Gumbiner: Most people don't want to take the responsibility. They want the leadership, power, and prestige, but they don't want to do the hard work, take the responsibility, the risk, or have the self-discipline. Some people will do the hard work but they don't want the responsibility or will give up immediate gratification for future gain.
- Hughes: How did the partnership work out the third time?

Gumbiner: That time it worked out pretty well. That went along for about ten years probably. I think that group broke up in 66. It was sort of interesting, a lot of problems developed with that group--mostly jealousy, hate, and envy. Those are the four horsemen of emotions and no one ever wants to talk about them.

Anyway, they were always fighting with each other and arguing. Finally, I brought in a couple of people from the UCLA [University of California, Los Angeles] Department of Human Factors and we had a good old-fashioned encounter group with all these doctors. We got everything out on the table; nobody liked anybody, nobody trusted anybody, and so we broke up after that.

Hughes: How did the partnership work medically?

Gumbiner: Well, medically it worked all right; the coverage and economy of size functioned.

During the ten years that I spent building another medical group, I realized that there was no system of payment that would ever satisfy the doctors in a fee-for-service partnership group. We started out with the usual payment for services in which each doctor got a percentage of his gross billings. That didn't work because people would get a percentage of their gross doctors' billings and then the group couldn't collect it. So we would be paying doctors for services we never got paid for. Some of the doctors were treating people excessively to build up their billing, and others were not following our fee schedule.

Then we tried a system where everybody split the after-cost income equally. That didn't work either because some people felt that they were working harder than another doctor partner, or they were attracting more patients and not getting paid for the extra effort.

We finally evolved into a system where everybody took a salary and then got an additional 15 percent of their billing. The idea was that the 15 percent they got on their billing would only be 5 percent of their group billing and be de minimus, therefore, they wouldn't do unnecessary work to generate the same amount. This didn't work either.

Hughes: Who was thinking up these schemes?

Gumbiner: I was thinking these up.

Hughes: Were you the leader?

Gumbiner: Yes, I was the senior partner and the so-called "developer." I developed the real estate, purchased the equipment with my money, financed the project, and took the risk.

Hughes: Were there any other senior partners?

Gumbiner: Eventually we were all equal partners; that was the problem. I was doing all the management work and all the innovation. They would see patients and they wanted me to see the same number of patients, take night and weekend call, do the management, and not get paid any more than they did because, of course, management wasn't worth anything. So I decided that was an unworkable situation, particularly after I started taking management courses at the University of California.

The Prepaid Medical Plan

Hughes: You realized how the partnership should have been working and wasn't?

Gumbiner: No, I decided that there had to be some scientific, rational way to manage things, so I looked in the UCLA catalog and found a couple of courses. The first course I took was in strategic planning at the downtown campus at night. I started taking management courses and I soon figured out that there had to be a management concept applied to the delivery of medical care. Simplistically, you had to be able to plan on how much income you were going to receive, then how much of that you had to spend for expenses, and how much you'd have left for new buildings, new hires, new projects, debt service, return on risk, and profit. You had to have a planned system. You couldn't have a planned system where you depended upon an unknown amount of income that would come in intermittently. Patients would come in, or they wouldn't come in, and the partners wanted to take all the money over direct expenses home every month, leaving nothing for reserves or bad times.

Hughes: So there was nothing to work with.

Gumbiner: Then I'd say, "So what would you do if you had a bad month?" "Well, we'd all come up with the difference." I'd say, "You're not going to come up with the difference because you spend all your money every month." Fee-for-service is a bad system for the patient because the sicker he is, the more he has to pay, and the less able he is to pay because he is not working or he has extra expenses. That's crazy.

Hughes: Is that an idea you developed on your own?

Gumbiner: Well, I don't know. But as I went around the hospital somebody would be lying in a hospital bed recovering from a heart attack, with insurance that paid half the bill, and he'd say, "Doctor, I'm worried about the bill." What could I say? Don't worry about it? That's sort of a stupid thing to say, right?

So it seemed to me that was the wrong way to do it for the consumer. It was also the wrong way for the doctor because the doctor couldn't plan on anything; had no security as far as income. What if the doctor got sick, what if patients didn't come in, et cetera. It seemed to me it was much better for the doctor if he worked on a salary, with a reserve for the down times and up times. That way you could plan on what was coming in and going out, et cetera.

I developed the first prepaid plan called the Family Health Program. We offered all of our services and ten doctors, four or five general practitioners and four or five specialists, for one flat amount per month.

Hughes: Do you remember what that was?

Gumbiner: It was some really small amount, like fifteen dollars a month. To take care of the patients' pharmaceutical problems, we started a small dispensary in part of the reception area and had about fifteen or twenty drugs. In those days all you needed was fifteen or twenty drugs. We bought them wholesale and we sold them at cost, and they were all prepackaged and prelabeled.

Well, we found out that many of our patients had poor or no hospital coverage. You've got to remember this in the context of the time. In the late fifties the federal employees and the state employees were the first to get health insurance. Before that, people in your position (as a state employee) had no insurance, none, zero, zip. A lot of people had insurance policies that would pay half their hospitalization, thirty dollars a day or something like that. Typically, insurance policies would pay a daily rate of thirty-five dollars a day and 20 percent of the extras.

The extras were the operating room, prescription drugs, and anything besides your room, board, and nursing. In those days the extras were about 20 percent of the bill and the room, board, and nursing were about 80 percent. These days it's done a flip. The extras are about 80 percent and the room, board, and nursing are about 20 percent. The average fee-for-service

hospital rate around here is about \$1,100 to \$1,200 a day, all-inclusive.

FHP's Two Hospital and Two Medical Plans

Gumbiner: So we developed two hospital programs: one for people that didn't have any hospital coverage at all, and one for people that had partial hospital coverage. The concept there was that we, the medical group, would pay the patient's hospital bills because it's the doctor who's spending the patient's money. The only decision the patient usually makes is the first decision, to go to the doctor. After that, if the doctor says you need x-ray or laboratory work or a procedure, the patient usually goes along. The doctor is, in effect, spending the patient's money, so why shouldn't the doctor pay the patient's bill if the patient pays the doctor a flat amount per month? So I put that system in.

Hughes: Did you get some sort of approval from your partners?

Gumbiner: Oh, I got the partners to agree to it.

Hughes: All of them?

Gumbiner: I don't know how we ran that. I think we ran a majority vote.

Hughes: Do you remember the concept being difficult to get across to them?

Gumbiner: No. They did it reluctantly, but they did it because each time we'd add a doctor, we'd have a doctor with no practice. You get to the point where six doctors are filled up with patients and a little bit overloaded. Say they're doing 110 percent and you add a doctor. That doctor is doing 90 percent of nothing. So if you keep growing, you've got to have some way of keeping the new doctor partner busy.

I'll never forget, one internist told me, "Well, I can't see more patients; I'm overloaded." I said, "Well, why don't get another internist in here?" He said, "No, I don't want to do that because that would cut into my income." So I said, "What do you want to do?" Because in medicine you can't not see the patients. If you get a reputation for not being available, then you don't have a practice any more. It's like riding a tiger. He who rides the tiger can expect to be eaten. You

can't get off the tiger once you get on because you'll get eaten.

We enrolled about 3,000 patients who voluntarily agreed to pay x amount per month. We had an initiation fee to keep people from dropping in and out of the program when they were sick.

Hughes: And they had the choice of two plans, right?

Gumbiner: They had the choice of two hospital plans. I think also we had a high- and low-option medical plan at that time where you could pay more per visit or less per visit, depending on the monthly rate. The theory of prepayment is that there is a stop-loss for the patient. In those days the patient paid a dollar for each office visit and that's all he would pay, no matter what was done. Or he paid three dollars on the low-option plan. You paid more for the plan where you only paid a dollar per visit and less for the one where you paid three dollars.

Then we had two hospital plans. We had, in essence, four plans. In other words, you could put ambulatory care plans 1 and 2 with the A or B hospital plan.

Recruitment of Long Beach Unified School District Employees

Gumbiner: A few of our patients who were on the individual plan were schoolteachers in the Long Beach Unified School District. The Long Beach Unified School District decided to provide health and accident insurance for their people. Kaiser Permanente and Blue Cross were bidding on it, and some of the people on the individual plan suggested that we offer our plan. So I offered the plan and put together a marketing pitch. Lo and behold, we got in there on a triple choice with Kaiser Permanente and Blue Cross. We were suddenly in the group business.

Hughes: Were you a bit surprised?

Gumbiner: No. I had figured out that in order to develop an organization you had to hire management before you could afford it.

Hughes: What was the logic there?

Gumbiner: What's the logic? The logic is that if you don't hire management that you can't afford, you're not going to get to the point where you can afford them. In other words, to get bigger

you have to get people to get you there and you have to have people to help you grow into it.

Hughes: Where were you getting the capital to get this new group of managers?

Gumbiner: At that point in time it was myself doing all the management work, with one nurse, Dolores Kellett, who was doing the operations, but I knew that wouldn't work. I had to have somebody do the marketing, somebody do the financial work, somebody to help me with the medical work, etc.

Hughes: These realizations came because you had gotten into a competitive situation?

Gumbiner: No, they came because I was beginning to study management techniques and I read that someplace. The entrepreneur that transfers himself from doing it all to an organization has to make that leap which he cannot afford. He has to get the money, either put it up like you do any other business (with savings), or he has to get it from debt financing.

Hughes: That was a business principle?

Gumbiner: That's right. That's a basic business principle; if you want to be a bigger organization, then you have to get the staff of a bigger organization while you are still a small organization, or you'll never get there.

Hughes: Was prepayment working?

Gumbiner: It was working reasonably well. In prepayment (it's true today just as it was then), if you get 70 percent of what you would have gotten if you billed fee-for-service, you're getting the equivalent of 100 percent because in fee-for-service you have a certain amount of collection loss--not everybody pays. These days if it's the 20 percent copayment on their insurance, you'll take at least a 10 percent collection loss. Then, in addition, it'll cost you 10 percent to collect it because you've got to send people multiple bills. Some you've got to send to a collection agency. There are all kinds of nasty things you have to do.

In addition, there is some undetermined amount, 10, 15, 20 percent marketing costs, that you have to pay or do yourself. An average doctor used to open up a practice and sit there; patients might never find him. Some way he had to market his services. Well, most of the specialists do that by going to every medical meeting, shaking everybody's hand, serving pro

bono on all the committees in the hospital, meeting everybody, shmoozing them a little bit, whatever.

Hughes: You weren't doing any of that?

Gumbiner: I wasn't a specialist.

Marketing the Medical Group to Referral Doctors ##

Hughes: Were you making sure you were visible in the community, for example, by being active in the county medical society?

Gumbiner: I was chairman of the local drive for cancer funds, and I was on the junior chamber of commerce board of directors. I did all these things that would make me known in the community to the consumer directly. At Long Beach Community Hospital I was chairman of the general practice section at one time. I went to all the county medical meetings, and I got a few referrals from specialists.

Hughes: Were you doing all this strictly for exposure?

Gumbiner: That's how you market your services.

Hughes: I know, but was your motive only marketing?

Gumbiner: Motive for what?

Hughes: Well, you could have been working for the cancer society because you have a benevolent nature.

Gumbiner: Well, you could be doing that, in addition to taking house calls every night, and working ten hours a day, but you probably wouldn't want to do that for very long.

Hughes: You've answered my question.

Gumbiner: You'd have to be crazy. [laughter]

Hughes: So you figured this was something you needed to build your program?

Gumbiner: I'm going to tell you: anybody that's in the junior chamber of commerce is not there because he thinks that's a good thing to

do on Thursday night. Every single one of them is there to build his own business or profession.

Hughes: But the cancer society is a little different.

Gumbiner: Maybe. Most of the people I know that work for the heart society or cancer society are not doing it purely for altruistic reasons.

Hughes: Well, there's no pure motive for anything.

Gumbiner: Anyway, I'm just pointing out that doctors have to market their services, whether they're specialists marketing to their referral doctors, or whether they're generalists marketing to the general public. They can't just sit there and wait for people to walk in or they'll be sitting there for a long time. IPAs [independent practice associations] are so popular now because that's the way doctors get patients.

Hughes: How?

Gumbiner: The IPA HMO organizations put the doctors' names on a list and they market these doctors to a group. You don't seem to be too knowledgeable in the business of medicine.

Hughes: No, distinctly not. [laughter]

Gumbiner: Well, it is a rat-race business, let me tell you that; very competitive and always has been.¹

Fee-For-Service Versus Group Practice Prepayment Medicine

[Interview 2: December 11, 1991] ##

Hughes: How did you get the idea for prepaid group practice?

Gumbiner: The problem with the fee-for-service concept is that it's a fee for every service. The patient never knows whether the doctor is adding additional service, procedures, tests and so forth to line the doctor's pocket, or whether the patient really needs them. It's easy to rationalize that you're just doing better

¹For better chronology, a discussion of FHP was moved from Interview 1 to later in the transcript.

medicine, more complete medicine, by doing more things to people.

Hughes: Was prepaid group practice a philosophical issue with you, or was it a practical issue concerned with problems collecting your fees?

Gumbiner: It was some of each. Every doctor has problems collecting his fees because medical care is a service that no one particularly wants to have. People delude themselves that they never will get sick, and [needing medical care] is not something they can plan on, outside of possibly a pregnancy. They don't plan to break their leg or have a heart attack, and usually don't reserve funds to pay for illness. Therefore, it's always a problem for a doctor to collect his fees.

Now, insurance and government intervention have helped, but there are still deductibles, copayments, and additional fees to be collected. One, I think it's probably unethical to charge a fee for each service, unethical on the part of the doctor.

Hughes: Why is that?

Gumbiner: It's just a natural tendency to supply more services in order to create more fees, or not provide adequate care if the patients cannot pay. Two, it's unethical to charge fees if the patient can't pay for them. So what are you going to do if a patient can't pay, not take care of him? Traditional American medicine implies that if you don't have any money, you're not going to get taken care of. The attitude that fee-for-service is better than salaried physicians implies that the fee-for-service doctor will give less quality care to people unless they get paid more. I think that's totally unethical.

Hughes: Were these sentiments that you had in 1961?

Gumbiner: I had them at that time, and they got more developed as I went along.

The practical aspect was that you cannot develop an adequate medical service for clients or patients without prepayment because you can't do any planning. You don't know what revenue is coming in so you don't know what part of the revenue to allocate to buy more equipment, expand facilities, hire more staff, or whatever you're going to do. You have no idea what the patient load is going to be so you cannot project that the revenue will or will not come in. Then the economy gets a little tight, and people don't come in to see the doctor

because they cannot afford it. You are then over-staffed in the fee-for-service group.

Now, we may say that medicine is a nondiscretionary service because if you get sick, you need to see a doctor. That's not exactly true. It's true enough if you have an acute cardiac episode such as a myocardial infarction, because then you're probably going to have to see a doctor or you're going to die. If you break your leg, you could get along with a crooked leg (some people still do that in the rural areas). But then that's probably only a portion of medical care that is delivered. There are a whole lot of other medical problems that can be deferred: if somebody has a backache, somebody has a headache, somebody has bronchitis, they have a this, a that, or the other thing and they may get better, let it go until it is worse, or they may use home remedies.

Just to digress, the Cubans have developed a whole herbal system of home remedies that they sell in herb stores for a few pennies a packet. The idea is to take the pressure off the traditional health care system by self-treating all the minor ailments that people have.

Hughes: Is that a government-sponsored system?

Gumbiner: Government-sponsored. The government actually went out and collected all the folk remedies and medicines that people have used in various places to cure common illness. They put it together in a source book and they developed the herbs to be sold in little packets.

In general, I would say that in hard times, probably 50 percent of a doctor's practice disappears. People just don't come in to see the doctor. They sprain an ankle; they put an Ace bandage around it in hard times. In good times, if they sprain their ankle they go to the doctor to get an x-ray to see if they broke it. In hard times, if they have athlete's foot or a skin rash, they go to the druggist and get some over-the-counter medication and rub on it. In good times, they would go to the dermatologist, not just the doctor but the dermatologist.

When you have a fee-for-service practice you can't figure out how to manage the delivery of health care because you don't know what your revenue is going to be for any future period. It's just impossible. That's one thing. The other thing is, of course, you're constantly trying to be a healer, a doctor, and a friend to the patient. On the other hand, if they don't pay you, you're trying to be a businessman and send the collection agency to garnish their wages. That's another problem and it

drives you nuts. Plus the fact that when you bring new doctors in to your practice they just have to sit there and wait for their practice to build up while you support them.

If you have prepayment you can pretty well decide you're bringing x number of new consumers in. You know that they're going to use five-tenths of an office visit per month, so much in the way of hospital beds (one hospital bed a year), et cetera, so you can plan for your hospital bed use or your facility size or your doctor staffing needs.

Lakewood Plaza Medical Group: Trying Out a Prepayment Program

Hughes: Were these problems that you had already encountered in the Plaza Medical Group?

Gumbiner: I had encountered many in developing two or three different fee-for-service medical groups, and I tried out the prepaid aspect of it for part of the practice. Our theory was to have about 50 percent of the practice prepaid and about 50 percent fee-for-service to see how the two would work. It soon became evident to me that the prepayment was a far superior system than the fee-for-service.

The doctors that I was dealing with at that time couldn't understand the economics. They will get about 30 percent less fees billed--not collected--on a prepayment basis than they would on a fee-for-service basis. However, the revenue is about the same because you never collect about 10 percent. It costs you about 10 percent to collect what you collect, and then 10 or 15 percent or more is spent in marketing your services, which many doctors do but they don't admit they're doing it. The fact that they go to all the medical meetings and try to meet potential referral sources, the fact that their wife gives lots of parties to people they don't really care about, the fact that they do community work in order to become known after they've worked all day, is all part of the marketing program.

So, 70 percent on a prepaid basis equals 100 percent on a fee-for-service basis, and my partners couldn't understand that; never could understand it. They always thought that their patients would come in for the same amount of services on a prepaid basis, that they'd all come to them, and thus, they could make another 30 percent. But that never would happen, never did happen, never could happen, and that was the basis of our disagreement. Plus the fact that in a situation where we

were all partners, these people could not understand the value of management; they had no idea. They thought that I should do the management (which I worked on in the evenings and on the weekends) and, in addition, I should share night call with them and see the same number of patients.

Hughes: Sounds like a good system. [laughter]

Gumbiner: Yes, I told them I wasn't going to do that.

Hughes: Why did they pick you to be the director?

Gumbiner: They didn't pick me; I picked them. I created the medical group, I recruited then one by one, and I hired them.

Hughes: But you recruited them first, did you not, for the fee-for-service group?

Gumbiner: That's right. I created the fee-for-service group and I recruited them for the fee-for-service group. They didn't find me; I found them. I was the entrepreneur that put it together.

Hughes: Yes, but you were putting it together for a different purpose. The people you recruited for fee-for-service weren't necessarily the people you would have recruited for prepaid group practice.

Gumbiner: Yes, well, I found that out later. But in those days I didn't know the difference, and I wasn't quite sure whether I wanted fee-for-service or prepayment.

Hughes: Where had you gotten the idea for prepaid group medicine?

Gumbiner: I first ran into it when I worked for Ross-Loos, a very early prepayment organization. As I told you, I ran their San Pedro office for a year. I had also read about prepayment. There were prepayment organizations back in the thirties. The fact is, Ross-Loos started during the Depression but there are organizations that started even before then, back in the twenties.

Hughes: What pushed you off in this direction? You were certainly not following the crowd.

Gumbiner: I was never too interested in that. [laughter] If you follow the crowd, you'll probably end up behind the crowd.

It's just plain logic. I just sat there and said, "You can't go on like this." There are fee-for-service groups right now that are doing the same damn thing. There's a group out

here called Friendly Hills that I talked to (it's a big group with about sixty doctors) and the reason they went from about ten or fifteen to sixty is because they got into prepayment.

I also looked at all the medical groups around. I used to do a lot of work with what was then called the American Association of Medical Clinics and was chairman of their committee on prepayment and chairman of their committee on care for the aged. This was an association of all the major clinics, like Mayo Clinic and Oxnard Clinic, from the big ones to the little ones. I looked around Los Angeles and thought, there are only two groups in Los Angeles of any size, and they were Kaiser Permanente and Ross-Loos.

Now there were some other groups, like Moore-White which subsequently went into a decline. There were other groups here and there--five doctors, ten doctors, even twenty doctors, but none of them ever got to 200 or 300 doctors where they could get an economy of scale. I said to myself, "Why is that?" The Moore-White group had been in business for fifty years, and there was a group here in Long Beach called the Harriman Jones group, which interestingly enough finally went into prepayment after all these years. They acquired another small medical group, which was at most a ten- to twenty-doctor group. They were forced into prepayment to compete and to get their marketing done. Then they overextended themselves with a new building and were eventually acquired by a hospital chain.

Any time you have a group that's run by doctors, it's bound to fail. It's like a university; everybody is politicking to gain control and no one really wants to manage. What do you say? A dean is like a fire hydrant is to a dog. The dean or the chairman of the department is chosen by the very people he or she has to manage. He has to control these people and they're the very people that selected him. So, they try to get rid of him. Either he controls them and gets something done (and then they try to get rid of him), or he doesn't control them and doesn't get anything done.

That's the way it is in a fee-for-service medical group. My partners did not consider the fact that I had financed the building, built the building, acquired the equipment, recruited all these people, done the planning, and took the risk. Once I made them partners they thought they had equal right to run this organization. We couldn't get anyplace and spent all of our time arguing, instead of planning progressively and getting something done.

Hughes: Were you paying yourself more?

Gumbiner: No, I wasn't getting paid anything for doing the management. My theory was that I would do the management and I would do less of the medical work. However, that wasn't their idea; they thought I should do the same amount of medical group, plus do the management and take the risk. I was getting paid the same thing they were getting paid.

Marketing the Program to the Public

Hughes: How did you go about recruiting 50 percent of your patients to the prepaid idea?

Gumbiner: I sold the idea to the people that were on our patient list. Of course they could have been a patient of ours and somebody else's at the same time. We sent them letters saying that we were starting this program and that for one flat fee we would provide all of our doctor group services. If I recall correctly, we had some people that went out and actually visited patients in their homes, explained the program, and signed them up if they were interested in it.

Hughes: You hired people to do that?

Gumbiner: Yes, the leads actually came off of our patient list. We had to hire representatives to then call these people. There hasn't ever been a service or a product that is purchased; they are always sold. You wouldn't walk around in clothing like that unless somebody sold you on the idea. You'd just put a sack over you and you'd be covered up, right? [laughter]

Hughes: You were marketing from the start?

Gumbiner: Oh yes, we had to sell the concept. I think I had a telemarketing group that worked in the evenings, that would call up people and explain the program to them. We also had people who made home visits. In fact, we used college students for a while.

Hughes: Did you train them?

Gumbiner: Yes.

Hughes: Was it a formal sort of thing?

- Gumbiner: I can't remember what we did, but I'm sure there was product orientation and basic presentation techniques. After all, everyone is always selling something.
- Hughes: Very early on you were doing this?
- Gumbiner: In the late fifties.
- Hughes: 1961 is the date you see in the literature.
- Gumbiner: That's the date we incorporated. I actually put this program together in the late fifties but I didn't bother to incorporate until 1960 or 61.
- Hughes: When did you put the Plaza Medical Group together?
- Gumbiner: I don't recall exactly. Let's see, I came to California in 1950, I worked about three years here and there, so I must have put Lakewood Plaza Medical Group together in 1955 or 56. Something like that. I worked as a solo general practitioner for about a year or so, until I figured out that was no good.
- Hughes: How much did this plan cost per month?
- Gumbiner: Now you're asking me to remember back thirty years. As I recall, this plan cost fifteen dollars a month, or something like that.¹
- Hughes: What did it cover?
- Gumbiner: Oh, it covered all the doctors' care, in the hospital and outside the hospital, preventive care, well-baby care, and obstetrics.
- Hughes: And the Lakewood Plaza Medical Group had all the prerequisite specialists?
- Gumbiner: No, all we had was a general surgeon, a couple of internists, a pediatrician, an obstetrician and, I think, five general practitioners.
- Hughes: Well, that covered most medical problems.
- Gumbiner: That covered about 80, 90 percent in those days.

¹\$14.00 per month according to FHP News, January-March 1962, volume II, no. II.

Hughes: What did you do with the other 10 to 20 percent?

Gumbiner: I think in the very beginning we charged a very moderate fee and we covered only our services. If the patient needed some additional specialty services, he had to go outside. Then we progressed from that to offer what we called the high-option plan where we paid additional doctors' services. You have to remember, in those days it was quite different. If you were a general practitioner and you had somebody with a heart attack, you took care of him, and only if it was something unusual would you call in an internist. Then he or she gave you consulting advice or took care of the patient. There wasn't any such thing as a cardiologist.

Nowadays, the internist takes care of the general medicine problems. If the internist can't figure out what's going on, he refers the patient to a non-invasive cardiologist, who then refers him to an invasive cardiologist. This results in a lot of bills. In those days, our basic x-ray machines took care of most everything and we had part-time radiologist who would come in and do our barium x-rays.

Hughes: And the lab work?

Gumbiner: We had our own laboratory.

Hughes: Was that pretty common?

Gumbiner: Yes, that was pretty common. You didn't have to do too much besides complete blood counts, urine, and a few blood chemistries. The lab tests were a lot less sophisticated and there were no automated labs. We were able to run our own laboratory and x-ray department and, in general, take care of 80 or 90 percent of the load. Actually, the general practitioner should be able to take care of 60 or 70 percent of the patient complaints.

Hughes: Is it true that you offered a 10 percent discount on pharmaceuticals if they were bought at two specific drug stores?

Gumbiner: No, I don't remember that. All I know is we had a dispensary in the front of the medical center where a nurse dispensed prepackaged, prelabeled drugs. You could easily practice with about twenty drugs, including one antihistamine and one antibiotic. You don't need sixteen antihistamines, ten tranquilizers, and fourteen different antibiotics.

Hughes: All of this was set up by you?

Gumbiner: I set that up.

The Partners

Hughes: What were your partners doing?

Gumbiner: They were practicing medicine and arguing with me. [laughter]

Hughes: They weren't involved with the organizational and business aspects?

Gumbiner: No, they weren't concerned.

Hughes: Was the main contention this 30 percent extra that they thought they should be making?

Gumbiner: No, I think the main contention was what I call the four horsemen--hate, greed, envy, and jealousy. Doctors are always jealous of each other in medical groups. You can never make everybody happy on how they split up the income. A certain amount of money comes in, a certain amount is paid out in expenses, and, theoretically, there's a certain amount left. If you split that up among the members of the group, then they get in a big argument about somebody who's working harder than somebody else, or X is seeing more patients than Y, and he wants to know why he isn't getting paid more. If you give them a percentage of their billings, then they accuse X of running up bills on deadbeats and draining the common cash pool, or they start stealing each other's patients within the group if you are on percentage billing.

The person that does the public relations--goes to all the community meetings and meets people to get them to know that you have a medical group--doesn't have time to see patients. So these patients see the other doctors in the group who get paid for seeing them. The person doing public relations gets nothing for doing that. It's a disaster.

Finally I got the notion that every doctor would get a flat draw per month (I think it was \$1,000) and, in addition, he would get an amount equal to 15 percent of his billing. The theory was that 15 percent wouldn't be enough to cause them to steal each other's patients and to complain or not work. That would translate into about 5 percent of their income so that they would get something for working harder. However, that didn't work either. On the prepayment side, we had one guy who

would do unnecessary surgery just to get 15 percent of the billing and never mind that he was running up our hospital bills.

Hughes: What were you doing about hospitalization?

Gumbiner: We just paid the hospital its regular bills, after we went through them and threw out the unnecessary and fraudulent charges, which are rife in hospital bills. Ever try to read a hospital bill? You can't understand it. It has all kinds of strange things on it, like ten dollars for transportation. What's that? That's for putting the patient on the gurney and wheeling him from his room to the x-ray department.

Hughes: Didn't protesting these fees jeopardize your hospital privileges?

Gumbiner: No, you just take a big red pencil and run a red line through the unauthorized fee and then send them a check for the balance.

Hughes: The hospitals needed the business?

Gumbiner: No! It was such outlandish thievery that the hospitals never contested the charge. They were happy not to be exposed so that they could continue to cheat someone else. Once in a while you'd get in a big fight with some anesthesiologist who would buy a new monitor and slap it on a patient's bill and try to charge him for it. But, in general, when somebody bills an unethical, illegal charge like that, as hospitals frequently do, then they never want to argue about that. They just hope that some insurance company will pay for it without knowing the difference.

Hughes: How many patients were in the group at the outset?

Gumbiner: We had 3,000.

Hughes: Immediately?

Gumbiner: After probably six months or a year.

Hughes: So there was a market for prepaid group practice.

Gumbiner: Yes.

Medical and Social Ostracism

Hughes: Do you think that the presence of Kaiser Permanente in this area had affected the market positively or negatively?

Gumbiner: Well, I think people knew what prepayment was all about through exposure to Kaiser Permanente, although they did say we were some kind of communist organization. Of course you have to realize that we were being bad-mouthed by everybody from the hospital administrators to other doctors and pharmacists for daring to do something new and different. As soon as you set up a dispensary for your patients and sell them drugs at cost, the pharmacists are not going to love you. And as soon as you start red-lining some of the hospital bills, and telling the hospitals you're not going to pay for things your patients didn't get, they don't love you. And as soon as you add a specialty to your own group, the other specialists in that specialty hate you.

Hughes: And all of that happened?

Gumbiner: Of course.

Hughes: Were physicians in prepaid group medicine socially ostracized?

Gumbiner: Oh yes. They worked on the doctors' wives. We had one doctor who left our group because his wife, above anything else, wanted to be accepted in the medical wives' community and they were giving her the cold shoulder. Then they would do the same thing to the doctors. Our doctors would go to the hospital, sit down in the doctors' room and wait for a surgical room to be vacant. Someone would say, "Oh, hello, doctor. Where are you practicing?" "Oh, I practice at so-and-so. Have a cup of coffee. Where do you practice?" "Oh, I work for the Plaza Medical Group." Then they didn't pass them the sugar.
[laughter]

Hughes: Was joining the local medical society a problem?

Gumbiner: No, I was in the medical society.

Hughes: Had you been a member before you started this group?

Gumbiner: Yes.

Hughes: That made a difference?

Gumbiner: Well, you could get in the medical society as long as you paid your dues.

Getting hospital privileges was something else again. Of course that's not unusual; the entrenched medical power structure does the same thing to the new fee-for-service doctors. In other words, if there's enough work for three surgeons in a town, and a fourth surgeon comes to town, guess what, he doesn't get hospital privileges. They say, "Yes, we'll be happy to give you hospital privileges as long as you do six cases of every type of surgery, and somebody must scrub with you to see if you can do the surgery correctly." How can he get the patients if he doesn't have hospital privileges? And of course they make it difficult for the new doctor to get a time to do surgery because they won't show up to scrub with him. On the other hand, Dr. Jones, who puts a lot of patients in the hospital, gets a partner, Joe, a buddy who owes him something, to scrub with him. They say, "Oh, Joe seems like a nice guy. He did those two cases fine, so we'll just sign him off." That's the name of the game called medical politics, medical economics, quality care, or whatever you want to call it.

Hughes: Any problems with organized medicine?

Gumbiner: The Los Angeles County Medical Association accused me of advertising.

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Hughes: How were you notified?

Gumbiner: Well, they used to write me letters asking me to come up and talk to the county medical association's board of directors.

Hughes: Somebody in the community must have tipped them off.

Gumbiner: Of course. My colleagues would complain all the time. They also hoped that I would go broke. [laughter] They told everybody that I would go broke providing all of that coverage for that small amount of money.

Hughes: Were you confident from the start that prepaid group practice would work?

Gumbiner: I didn't see why it wouldn't. I'll tell you why: the doctor controls health care. This is the only service that I know where the person that receives the service does not order the service. In essence, the doctor spends your money. The only choice that you ever have is the first visit that you make to the doctor. Thereafter, in general, if the doctor says you have to have this test or that test, you have it.

Once in a while you get a patient like me. I had to have some surgery and I went to four different universities, talked to all the heads of departments about this particular surgery until I decided who I was going to have do the surgery and what I was going to let them do to me. I also asked them how much they were going to charge me. But that doesn't usually happen.

I had a good friend, who was a professional negotiator around the world, and somebody told him that he had cancer of the lung. He interviewed every prominent lung surgeon and thoracic surgeon in town and then he hired one to do the surgery and hired his second choice to assist. He also interviewed all the anesthesiologists and made a deal with them as to the price they were going to charge him, and only then did he hop up on the table.

Hughes: That is the exception.

Gumbiner: That's right.

Taking Management Courses

Hughes: In 1955 you took a business course. I believe it was the first one you'd ever taken?

Gumbiner: Well, I started taking management courses.

Hughes: Before that you mean?

Gumbiner: No, I mean about 55.

Hughes: How much of what you were learning through business courses and your own reading affected what you were doing in the medical group?

Gumbiner: A lot. It made all the difference. I must have taken a couple of hundred business courses. If I wanted to find out something about personnel management, I'd take a semester's course at one of the universities. I took a bunch of courses in the human factors department on conflict management and all kinds of things. I took maybe four courses in setting up computer systems. I took three different courses in taking companies public. When I acquired an insurance company, I must have taken a half a dozen insurance courses. I'd take them through the American Management Association, through various universities, university extension, and various other places.

- Hughes: You found that these business principles applied directly to the HMO industry?
- Gumbiner: Of course. Management is management and no matter what you do, you have to deal with people. Management is a people game; it's not a numbers game. The only difference is that in the HMO there is a higher proportion of knowledge workers.
- Hughes: Why do you say that?
- Gumbiner: Why? Because some people think it's the numbers--a bunch of people with accountants' brains--and they never succeed.
- Hughes: You mean you should try to get the most out of the human resources that you have available?
- Gumbiner: Yes. If you get the right people and they understand what you want to do, then you can succeed.
- Hughes: Yes, but that's a big "if."
- Gumbiner: That's what you do; that's the name of the game. You have to find the right people, you have to have a plan and a goal that everyone understands, and you have to structure your organization. Organizational structure is something that most students in business schools don't pay any attention to, and they should. They're too busy studying Accounting 101A, or some stupid other thing they can hire somebody to do.
- Hughes: Well, let's get back to those early days.
- Gumbiner: We haven't gotten out of 1955. We'll be here for the next ten years. Let's move it along.
- Hughes: [laughter] It's all relevant, believe me.

Recruiting Outside Patient Groups

- Hughes: At first, as you've said, the group was limited to your patients. When did you begin to expand beyond the patients of the Plaza Medical Group?
- Gumbiner: We must have had the prepaid program going for a year or so. Some of the people who were in that original group of patients were schoolteachers for the Long Beach Unified School District. One of them requested that I offer a program to the Long Beach

Unified School District on a group basis. You've got to remember, back in those days hardly anybody had health insurance. Then, as I've said, we bid on that and ended up providing health care, along with Kaiser Permanente and Blue Cross, to the Long Beach Unified School District. That was our first group. I think subsequent to that we got into the City of Long Beach. Then I spent a few years trying to get into the California state system and then the federal employees' system.

Hughes: How were you going about that?

Gumbiner: I figured out that the biggest and the most stable employers would be the federal and state governments. No matter what the politicians said, those groups would always continue to increase in size and would never reduce their employment. So, I determined that I would get the local school districts, the local city employees, the state employees, and the federal employees.

Presentations to the California State Board of Retirement

Hughes: How did you get them?

Gumbiner: How did I get them?

Hughes: Yes, specifically.

Gumbiner: I found out that the people who could make the decision were on the [California] State Board of Retirement and that they had quarterly meetings at which time they made these decisions. So I went to Sacramento and made a presentation at that meeting and asked for the contract.

Hughes: And you got it?

Gumbiner: No, I didn't. I got thrown out a couple of times, but I came back year after year. [chuckles] In fact, in the federal program you could only apply every two years, so it took me six years.

Hughes: Was your eventual success due to general acceptance of the concept of prepaid group practice?

Gumbiner: No. They had legislation at the state level that said they would have one indemnity carrier, one service carrier, and HMOs.

Hughes: You'd better explain.

Gumbiner: Indemnity insurance is where they indemnify you for each medical service. For instance, if you have pneumonia, you go to the hospital and they give you x number of dollars for pneumonia. If you have your appendix taken out, they give you x number of dollars for an appendectomy. They indemnify you for a procedure. Fundamentally, the stop-loss is for the insurance company, not the patient. If the insurance company allows you \$500 for an appendectomy, that's all they are going to pay you. That's a stop-loss.

Service insurance is like Blue Cross where, fundamentally, they are going to cover you for everything you have done on an outpatient basis, or so much a day while you're in the hospital, not for each procedure.

The legislation said that the state employees would have one indemnity carrier, one service carrier, and then they would have multiple group practice prepayment organizations. Whoever put that legislation together was smart enough to figure out that a given group practice organization couldn't be all over the state. In those days if you were in Bakersfield, you couldn't get Kaiser because they weren't in Bakersfield, but you could get Blue Cross and, I think, Cal West had the indemnity program.

I read that legislation, I did a little research, and I presented the idea to them that they should have multiple group practice prepayment organizations in various parts of the state.

Hughes: When was this?

Gumbiner: When you were a little girl.

Hughes: Don't count on that. [laughter] Who had put in the stipulation that there had to be multiple prepaid groups?

Gumbiner: I don't know. It was a California law.

I'll never forget that final presentation. I went to Sacramento and did a slide show. They'd never seen a slide show presentation before at the State Board of Retirement. The slide show showed our facilities and some unique features of our program. I went to Sacramento early in the morning for a nine o'clock meeting. I got to the meeting room at eight o'clock and set up the slide show for a practice run-through, only to find out my slide projector wouldn't work.

I was trying to figure out how the hell I'd get another slide projector at eight-thirty in the morning in Sacramento. However, it was just that the slide carrier itself was malfunctioning. It made me realize that I should always carry two projectors, two sets of slides and extension cords. Basic management philosophy is that you always have a backup.

Hughes: How did you get out of that situation?

Gumbiner: I thought it through and realized that it was simply the base of the slide projector that needed adjusting.

We had just changed governors, if I recall correctly, and Reagan had just been elected. A man by the name of Lester Breslow, who was later dean of the School of Public Health at UCLA, was the head of the California Board of Health. Reagan had come in but he had not gotten around to replacing Breslow, and this was Dr. Breslow's last meeting as a member of the State Board of Retirement. It's strange, but that agency does take care of all the health benefits and everything else for state employees. He wanted preventive care included in the health benefit package. They had breathed a big sigh of relief that he was going to be fired (he was going to be terminated the following month) because then the staff would not have to bother with additional benefits.

I was in the middle of my presentation and Breslow walks in, takes his seat knowing this is the last meeting he's going to be attending. I had never met this man before in my life. I went through this whole thing--that we were located in Orange County and Kaiser Permanente wasn't in Orange County, and that I thought Kaiser Permanente was monopolizing the state employees' program. I get all done with the presentation and there's dead silence. Then I felt this presence behind me. Robert Erickson, who was a senior vice president at Kaiser in charge of legislative affairs, was standing there protesting that Kaiser was not monopolizing and they'd be happy to have another little plan like ours included. He sat down but I was still standing. I said to the chairman, "Mr. Chairman, is someone going to make a motion on this?" The chairman hated group practice prepayment and would have been happy never to have another plan added to the state program. He said, "I don't make motions. Next item of business." Breslow said, "Just a moment. I think a good small plan can deliver care just as well as a large plan, and I make a motion that we accept this plan to provide care." Since he was a doctor, and the head of the State Board of Health, and this was a health issue, somebody said, "I second it." And they voted us in. There was a moment there, however, when we could have failed.

Hughes: What is the date of the complete demise of the fee-for-service aspect of the Plaza Medical Group?

Gumbiner: 1966. The members of the medical group were all fighting with each other and simultaneously they were all fighting with me and we weren't getting anyplace.

The idea had been that a person would work there for two years and then we would elect him to be a full partner, not a junior partner. This was a mistake, however. I was pretty stupid in those days; I took nothing for my management time and I just gave away these partnerships for nothing. I think new partners just paid off the receivables of the previous partnership (i.e., partnership number four be buying out the receivables of number three, and number three would be buying out number two).

Recruiting Physicians for Group Practice Prepayment

Gumbiner: I had just taken a course in the human factors of management at UCLA. Two Ph.D.s in the school of business in the human factors department taught the course. I'd drive clear up to UCLA from Long Beach every Thursday night for a whole semester. We tried to figure out the ideal person to recruit for a group practice prepayment: someone who would fit into a group environment, be flexible enough, just wanted to practice medicine and not worry about the business aspect, and did not want to be captain of the team. By having coffee with these two professors after class, I was trying to figure this out. What we figured out was that we couldn't figure it out. We could not make a profile--it's true to this day--of the personality characteristics of a doctor who was apt to be most successful in group practice prepayment.

Hughes: Why?

Gumbiner: Because the applicants didn't know what they wanted themselves.

I had a whole series of questions that I would ask applicants. I'd say, "Well, what would you like to be doing in another five years?" The guy would say, "Well, I'd like to be in solo private practice by myself." Obviously, I didn't need that guy, right?

Hughes: Right. [laughter]

Gumbiner: "What would you like to be doing in two years?" "Well, I'd like to have your job." I didn't need him either, unless I was ready to retire. Doctors really don't have a life plan; they don't know their own personality and don't know what they want to do.

Hughes: Didn't you also find that they didn't really understand what prepaid group practice was?

Gumbiner: Right. What we decided was that we would create a model which would be easy to understand. If I said to them, "This is a model of a general or equal partnership and after two years you become a full partner," they then assumed that with a little hard work, a little political maneuvering, and a few stabs in the back, they could become head of this partnership. Right? You may have some people in the partnership who want to be captain of the ship. They may not want the responsibility, but they want to be captain of the ship. So we decided to create a different model; that is the staff model HMO, or in those days, group practice prepayment program [GPPP].

Hughes: The staff model did not exist before you thought it up?

Gumbiner: Well, it may have existed someplace else, I don't know. Kaiser has sort of a staff model (it's really a group model).

Hughes: Kaiser Permanente would resent being called a staff model.

Gumbiner: But they were a staff model practice type.

Hughes: Why do you say that?

Gumbiner: Who else are the doctors going to negotiate with but Kaiser? They can't take their medical group and sell their services to somebody else. They claim that they are self-governing. When they need a new medical director in Oregon, the Oregon people are all fighting with each other and, lo and behold, the medical director materialized out of San Diego. [chuckles] When they went to San Diego, they asked Kaiser Permanente south to staff San Diego. Kaiser Permanente south said, no, that it would cut into their income. They were told, fine, Kaiser Permanente north would staff it. Guess what happened, Kaiser Permanente south immediately jumped up and staffed it.

So we made a model, a straight staff model, where there was a management team--a chief executive officer and a chief operating officer. If you were a doctor, you worked as a doctor in this organization for your entire career unless you wanted to be head of a department, and then you worked partly as a manager and partly as a doctor. If you wanted to be a medical manager,

you didn't work as a doctor but worked as a medical manager. We have medical managers that have worked their way up to senior management positions. In fact, we have one that's running our San Diego unit. The model was that doctors practice medicine, managers manage, and neither interferes with the other.

An applicant says to you, "I only want to practice medicine; that's my whole goal in life, and for the next thirty years that's what I'm going to do." But subsequently he really wants to be head of the organization and tell everybody what to do. He looks at this model that tells him he can't be a doctor and in his spare time tell people how to run this organization. If he's a doctor, he's going to practice medicine; that's it. He tells you to forget it and that he's not joining this type of an organization. So, subconsciously he rejected the model. That approach worked perfectly. We didn't have to do psychoanalysis on every doctor who applied because their subconscious rejected that model.

Hughes: By selecting people according to that model, I would think that one hazard would be attracting plodders.

Gumbiner: If you take that attitude you'd say that everybody that ever goes into any business in the United States and works for a salary would be a plodder. Besides, you would have to say that about almost all university professors, wouldn't you? They all work for a salary, and most work as professors all of their lives.

Hughes: Well, most businesses offer an incentive; there's a chance for promotion.

Gumbiner: If you want more challenge, you can get into medical management and become head of your department. There are always different incentives. The longer you stay, you get additional income--you get bonuses for this and that.

Hughes: At what point did you have to expand the medical group beyond the Plaza?

Gumbiner: I was getting to it. I was giving the background to this climactic, dramatic episode in 1966.

Hughes: Go ahead, it's all yours.

Demise of the Lakewood Plaza Medical Group, 1966

Gumbiner: After I talked to these professors and we created this theoretical model, I decided to go one step further. I got everybody to agree to dedicate one Sunday to trying to solve the partnership's control problems. We rented a room in a hotel and hired these two professors from UCLA to conduct an encounter group. We'd lay everything out on the table and get rid of all the animosity. It ended up that we were having these partnership meetings until three o'clock in the morning and each person took a position that he would never change. One guy was like Edgar Poe's raven, saying "Nevermore." He would say, "It'll never work. It'll never work."

We had this encounter group and everybody showed up but the surgeon, which was a pretty interesting sign because he was the most disturbed of them all. Surgeons in general like to cut someone up in the morning (particularly mothers, if they're gynecologists). Surgeons don't have to talk to people; they just have to open them up. We had this encounter someplace in Huntington Beach, and that did it.

Hughes: In what sense? Did it in? [laughter]

Gumbiner: Yes, that did it in. Everybody laid it on the table. The anger flew all different ways: "I don't trust you; you're no damn good; you're a thief; you're incompetent."

Hughes: Which was not what you anticipated.

Gumbiner: It was exactly what I anticipated. Within thirty days that group was dissolved in sort of an interesting way. We had the encounter group and then shortly after I went on a vacation. During my vacation the partnership had a meeting and voted to do away with all prepayment, which was 50 percent of the revenue, on the idiotic notion that all these patients came to them because they were such great doctors and received all their services from them.

I came back and said, "I'm not going to put up with that." I went to lawyer and said, "What am I going to do?" He said, "Well, there's nothing in your partnership that allows you to dissolve the partnership, but you could object to being part of something that's going bankrupt."

We had a meeting and I said, "Well, considering that you want to get rid of one-half of our income by canceling group practice prepayment, I think you're going to make us all go

broke. I move that we dissolve this partnership because we don't seem to be getting along." One of the fellows, I think it was the internist, stood up and said, "You can't do that. I moved that we dissolve the partnership one day prior to your motion to dissolve the partnership." I said, "Good, I second that. Let's all vote." We all voted to dissolve the partnership on this date instead of mine.

Hughes: What was his point?

Gumbiner: Control. [laughter] He wanted control, to be the one to dissolve the partnership, not me.

As we walked out, one of the other people (I think it was the gynecologist), asked, "By the way, what is it we voted for?" [laughter]

My second in command, Charles Lifschultz, who I thought would stick with the partnership, was going to leave for Europe two days later so he didn't do anything; he just left with everybody else. We had two buildings, so the partners took the building in Los Alamitos. The pediatrician, Charles Eubanks, came back. He did an about-face the next day and walked right in the office and said, "I changed my mind."

Hughes: Why did he change his mind?

Gumbiner: Because he didn't want to go out and try to build a practice!

Volunteer, Mississippi Civil Rights Movement, 1966¹

Gumbiner: I went down to Mississippi for a while with the civil rights voter registration groups. I was working with the American Association of Medical Clinics and with Physicians for Social Responsibility on that trip.

Hughes: Doing what?

Gumbiner: Nothing, I did nothing. I just sat around.

Hughes: You did not. [laughter]

¹For better chronology, this section was moved from its original position later in the transcript of Interview 2.

Gumbiner: That's right. I just wandered around Mississippi saying hello to people.

Hughes: What were you saying?

Gumbiner: I said, "Vote."

Hughes: This was a personal crusade?

Gumbiner: It wasn't a crusade. I was sitting in a meeting of the Physicians for Social Responsibility and they said, "We need a doctor to go down to Mississippi and make sure the voter registration people are not dying of this thing and the other; reassure them. Does any doctor want to go?" I raised my hand and my hand was the only one up, so I went.

Hughes: Why did you raise your hand?

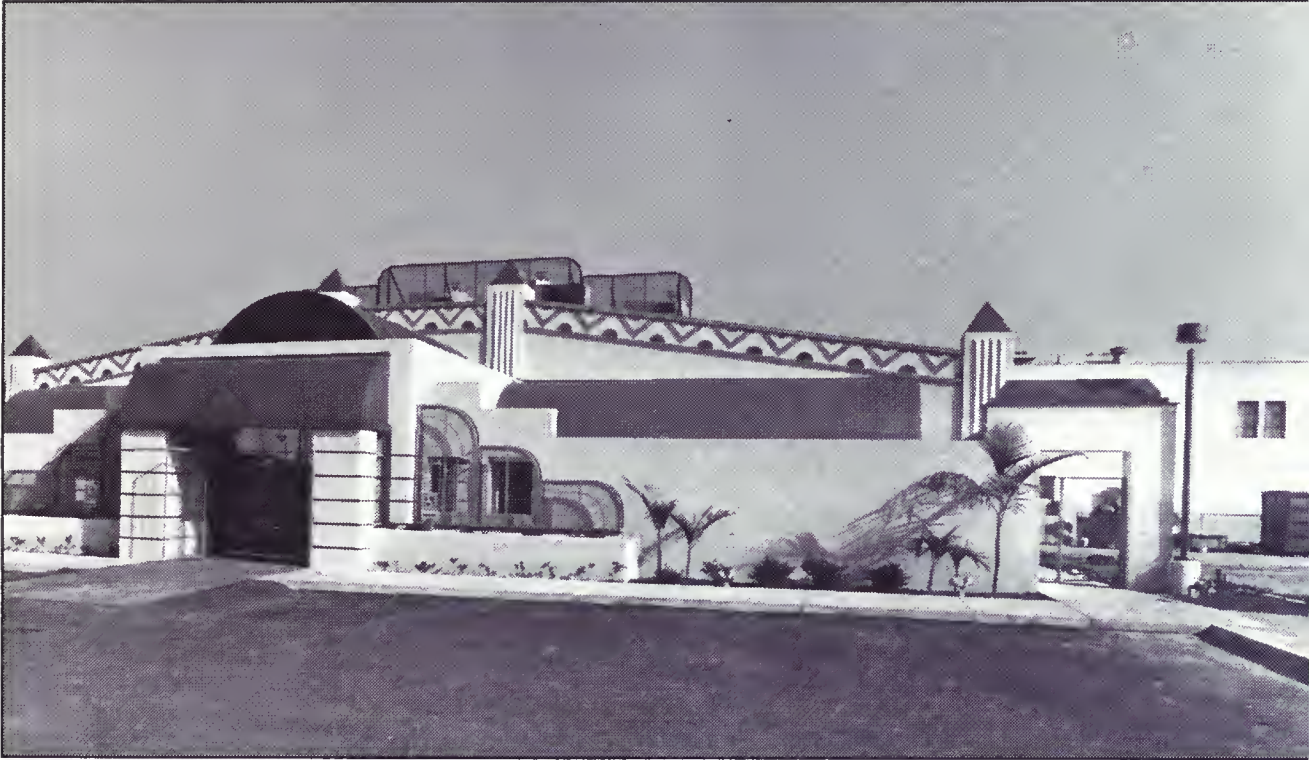
Gumbiner: I thought it would be interesting. Something to do. [laughter] A black psychiatrist went down there before me who spoke with a Boston accent and had never been outside of the Northeast. [sarcastically] They loved him in Mississippi.

Hughes: How did they love you?

Gumbiner: Oh, I went in disguise. During the daytime I was looking at medical clinics for the American Association of Medical Clinics and in the evening I was working for the voter registration people.

Hughes: What were you doing?

Gumbiner: I was moving around, talking to the voter registration people, reassuring them they weren't dying of various diseases.



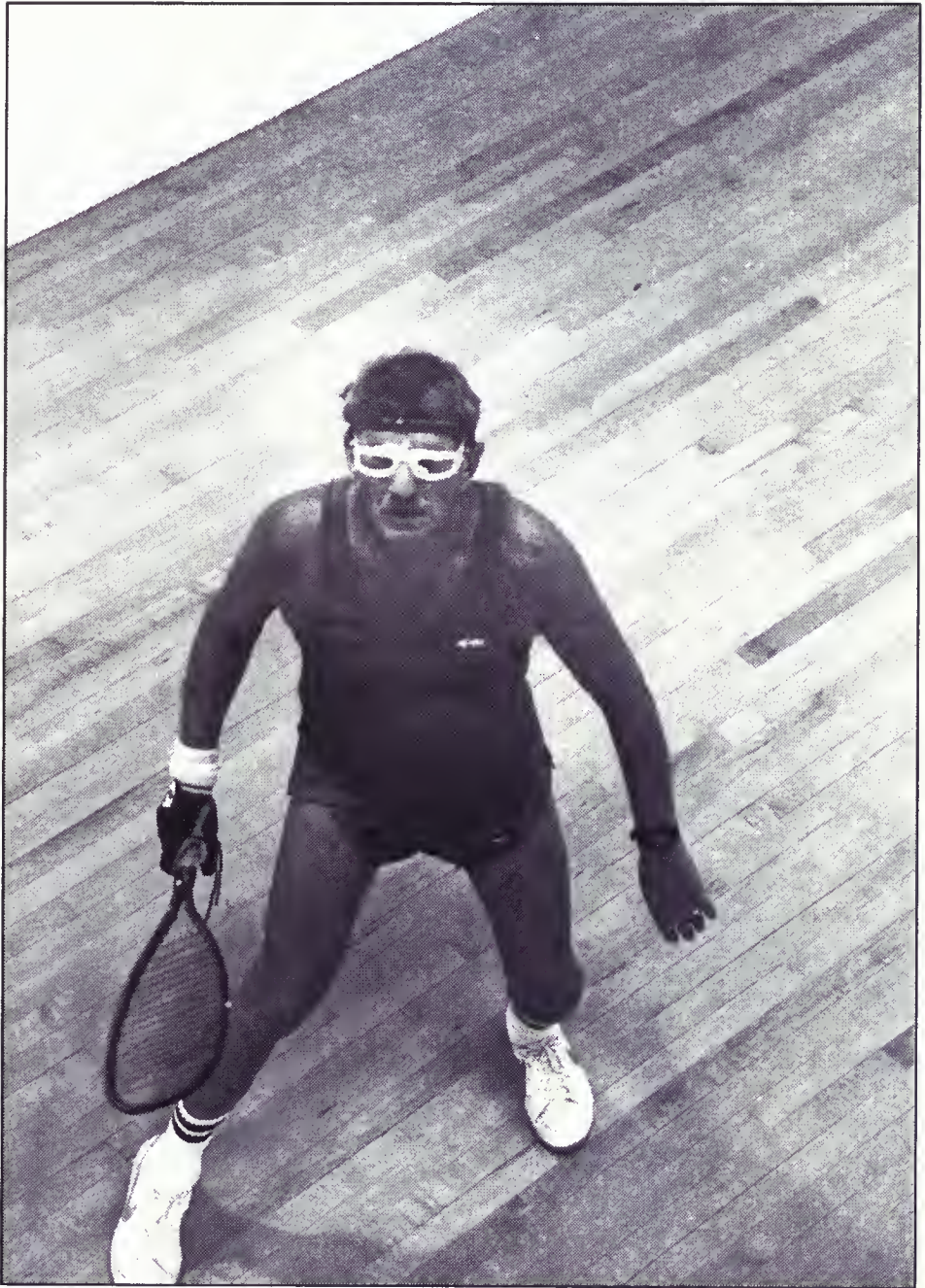
The Senior Health Plan Center (the Hippodrome) in Long Beach, 1983.



Fountain Valley Hospital groundbreaking, 1984. Left to right: Fountain Valley city official; Westcott Price, FHP; Robert Gumbiner, FHP; Harold Johnson, FHP; Randy Bosch, Project Architect; William Rosecrans, FHP.



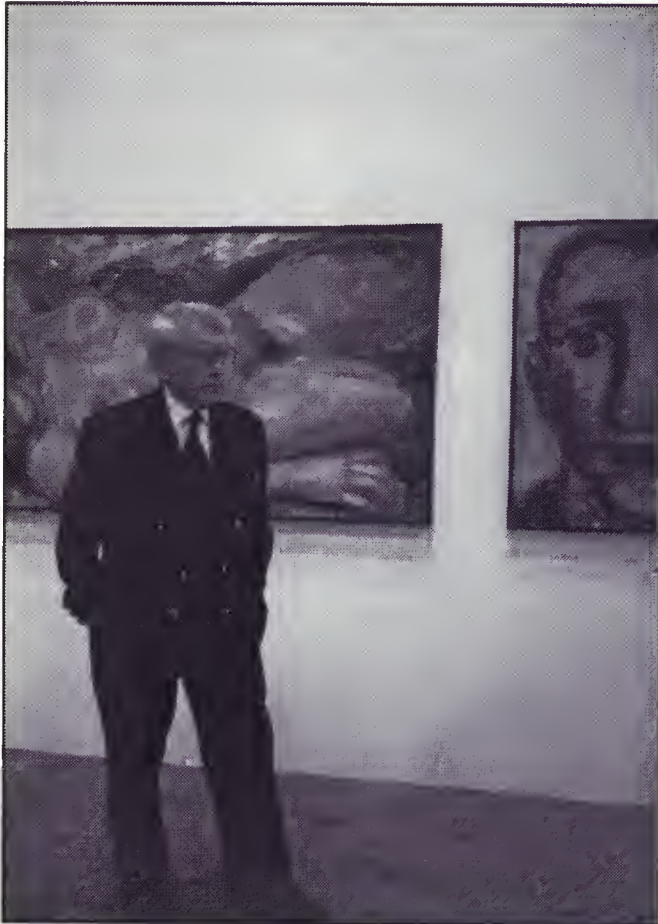
The FHP Fountain Valley Campus, 1986.



Robert Gumbiner playing racquetball.



Above: Robert Gumbiner (center) at his retirement party, April 1991. Left to right: Tim Brady, Westcott Price, Allen Mintz, M.D., and Randolph Stone.



Left: Robert Gumbiner at an art show, 1993.

IV FHP, INC.

Building a New Prepaid Practice Group, 1966¹

Gumbiner: In any event, this partnership broke up and, freed from the partners' interference, we were able to develop and expand the prepayment coverage very quickly. Since I was able to bring doctors in on a salary and with realistic benefits, I was able to plan, set up reserves, and run the thing like an organization should be run.

Hughes: So you were applying business principles?

Gumbiner: Right.

Hughes: Did any of those original nine partners stay with you?

Gumbiner: Yes, one, Charles Eubanks. This pediatrician quickly scoped out the situation and decided that he didn't want to be in private practice and came back.

Hughes: Did he try private practice?

Gumbiner: No, he did an about-face the next day. [laughter] Years later the obstetrician tried to come back and we wouldn't hire him, and one of the general practitioners, Charles Lifschultz, is now working for us.

Hughes: Why didn't you hire back the obstetrician?

¹Sections of a previous discussion have been incorporated here.

Gumbiner: Because he had bad judgment and poor patient relationships. But when you're in a partnership you have a hard time getting rid of someone because all the partners have to vote on it. They'll tend to lock their horns around their wounded comrade.

Hughes: All of a sudden you had a manpower problem. There were two of you when there had been ten.

Gumbiner: Well, I worked a lot of hours, to tell you the truth. The two of us worked a lot of hours. We took in a lot less money than we were making before and we didn't pay rent for the two medical buildings I owned.

Dr. Eubanks and I got together and bought all the equipment in the Lakewood Plaza building, as well as bought out the partners' shares of the pharmacy, which was failing. Fortunately, I owned the two buildings we had at that time. I then rented the one building in Los Alamitos to the four ex-partners and they bought the equipment owned by the partnership. I recruited a few more doctors and we took off.

Hughes: Now, don't slide over that. I wouldn't think it would be terribly easy to recruit to a prepaid group practice at that time.

Gumbiner: Well, you had to have talent to do that. [laughter]

Hughes: How did you sell the idea of joining a prepaid group practice?

Gumbiner: I offered regular hours, time off, and a greater income. Most groups in those days would bring a new doctor in, they'd give him a salary for six months, but after that he'd get a percentage of his gross and he was on his own.

I found a husband and wife team to join me and then found another doctor who had just left his residency. Now there were five of us. Remember, one-half of the practice was fee-for-service and a good portion of those patients left with the other doctors. On the prepaid side we kept 80 percent, or probably 20 percent of the fee-for-service, and 80 percent of the one-half prepaid, equalling about 60 percent of the total for one-half the doctors.

Hughes: Prepaid group practice was a new concept. It was certainly not anything that the local medical society or the AMA or the CMA [California Medical Association] approved of. It must have been rough.

Gumbiner: It was difficult to hire people. What you would get were people that were short-term. In other words, you were building with people who didn't plan on staying.

Hughes: And you knew that?

Gumbiner: I knew that, they knew that; they just wanted to be there a year maybe. The first fellow I hired just didn't want to work. He was a pretty good doctor but he was just too lazy. So he took a job being a doctor for the student body at a state university. How sick can a bunch of kids in their early twenties be, right?

Hughes: Well, they get a lot of mono[nucleosis].

Gumbiner: They get VD is what they get. Anyway, in the old days they just got VD but didn't get serious illnesses. You don't see that many people; you sit around and swat the flies. This doctor was a little lazy but his wife was much more aggressive than he was; she eventually divorced him.

Hughes: Were you taking anybody that happened to have an M.D. behind his name?

Gumbiner: No, no, I checked their backgrounds very thoroughly.

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Gumbiner: Management was the key to success. I had to hire these doctors in reasonably short order. I had part-time doctors helping me out while I staffed up.

Hughes: You still had a group of patients you had to serve.

Gumbiner: There was the school district, the City of Long Beach, and the group of patients in the Plaza Medical Group. Eighty percent of the enrollment stayed with the new organization.

Choosing the Doctor or the Plan

Gumbiner: I wrote an article with Dr. Milton I. Roemer from UCLA on that break-up, and reported that 80 percent of the patients chose to desert their doctor and stay with the plan.¹

Hughes: How do you explain that?

Gumbiner: Easy. Eighty percent of the people don't have a doctor they go to all the time; they don't get sick that much. They may think their doctor is Dr. Jones but he's been dead for two years. [laughter] It was a big disillusion to the doctors that the average person doesn't really care what doctor he goes to. There are some people who only go to one doctor and will die waiting for him or her to come back from vacation. There is another group which usually goes to one doctor but if that doctor isn't available they'll go to another doctor. Another group doesn't care what doctor they go to.

Hughes: Yet a member of FHP does have a choice of any physician he or she wishes.

Gumbiner: That's right. But what I'm saying is, a third of the people only wants to go to one doctor; they want their choice. Another third usually likes one doctor but they'll take another. And another third doesn't care what doctor it goes to as long as somebody with a white coat on who seems to know what he's talking about takes care of them.

Hughes: Is this an impression of yours or have you actually studied it?

Gumbiner: Well, I've experienced it and to my way of thinking it's a pretty valid assumption. Where a person belongs, in what third, has very little to do with his social, economic, or educational level. A busy executive will come in and say, I just want to use a doctor, I've got a skin rash, an earache, or whatever; you name it.

Hughes: Yes, but if you have a serious illness and you suspect it's going to be a long-term relationship, you're probably pickier, aren't you?

¹Robert Gumbiner, Milton I. Roemer, and Shirley Rich. "Research report--The doctor or the plan: A test of family priorities." Inquiry 1967-68, 4:59-61.

Gumbiner: No, it depends upon the person. Some people wear clothes just to cover their body, right? And other people are very particular about what clothes they wear. Amazingly enough, some folks with serious illness will go to any doctor.

My partners thought that when they got rid of prepayment, all these patients would come to them. But as a matter of fact, it was exactly the opposite. Eighty percent of the prepaid members left their doctors, four doctors moved to Los Alamitos, and two doctors went other places in town but didn't leave the area (they were close by).

The fact that the consumers stayed with the plan makes sense because 80 percent of the people are not sick very often and don't have doctors. They are more interested in having their health care covered when they need it, as well as easy access.

That's a lesson to be learned by the federal government right now too, I can tell you. All this talk about selection of doctors and free choice is garbage. Patients will usually go to a doctor who seems trustworthy, talks to them, and gets along with them. They don't care who that is as long as he looks like a doctor and seems competent.

Getting back to the formation of the new medical group: the third doctor I hired was number two in his class at USC [University of Southern California], a good medical school. He was a very personable guy but I thought there was something funny about him because he had quit his residency in anesthesiology at USC. When I called his references I said, "Do you know somebody else who knows him?" They would say, "Nah, he's okay." I finally found somebody that said, "I hear that when he was in his anesthesiology residency, he got more medication than his patients did." The guy turned out to be a drug addict and an alcoholic. After I fired him, he was back in fee-for-service practice and could have gotten away with this for many years in private practice.

We were able to quickly staff up, and probably within a year and a half, I had ten doctors in the organization.

Hughes: Where did you find them?

Gumbiner: Well, I recruited them. I'd started recruiting before this group broke up because I figured it wouldn't hurt to recruit to see who was out there. I had a suspicion that things weren't going to work out.

Hughes: Were they good doctors?

Gumbiner: What is a good doctor? Is that somebody who works hard and diagnoses accurately, communicates well with people, or just what is a good doctor?

Hughes: Well, I think those are all ingredients.

Gumbiner: You're right, but what is the priority?

Hughes: Well, maybe there's not one. Maybe you need a whole group of attributes.

Gumbiner: There are doctors who are very sincere but they're stupid. There are other doctors who are very bright but they won't work or cannot relate to people.

Hughes: But you must have had ideas about what you were looking for.

Gumbiner: Well, I was fairly selective.

Hughes: The doctors were working for you?

Gumbiner: They were working for the organization.

Hughes: Which you called Family Health Program?

Gumbiner: That was called Family Health Program.

Hiring and Firing Physicians

Gumbiner: To test the appropriateness of the potential doctor, I would take the doctor and his wife to dinner. I would say to him, "Are you sure you realize that you have to take night call every other night? Are you sure that doesn't bother you?" The doctor would tell me that didn't bother him but his wife would be going "Grrr" in the background.

Another test was that I would take a particular doctor out and say, "How would you like a drink? I'm going to have a martini." The doctor would say, "I'll have a triple." He took his triple drink, drank it, and I would say, "Would you like another drink?" He said, "Yes, I'll have another triple." He would then have another triple and then even a third triple and it didn't seem to bother him at all. I then knew that he was a

big drinker. This personal approach to qualifying a candidate was very important.

I checked doctors out very carefully and I did all kinds of things besides taking them out to dinner. For instance, I talked to their wives or their girlfriends. Thus, with these techniques I was able to build up a better group of doctors because I had control of the situation.

Hughes: You were also looking for a mix of specialists?

Gumbiner: Well, I always had a policy to have half general practitioners and half specialists. We knew what the incidence of various illnesses was in a prepayment group, so we were able to select specialists ahead of time, depending on that mix. However, it's always difficult to recruit people. I would only take, maybe, one out of five doctors that applied because I would always find things wrong with most applicants.

If a doctor had been in private practice, it was hard to check his records. The doctor will tell you, "Oh, I was in solo practice for ten years," and how are you going to check him? You would check with the hospital administrators, the medical associations, and check with his partners, if any. It isn't as if he had a work history. I checked one doctor clear back to an army career and found that he couldn't get along in the army. The telling point was that his commanding office gave a party when he left because he was so glad to get rid of him. [laughter] The man couldn't get along with authority or with groups.

Hughes: When you were interviewing these people were you trying to determine their philosophical stance regarding the type of medicine that you would require them to practice?

Gumbiner: Well, like I said, I carefully explained the model to them and if they wanted to do things their way or gain control, most of them would reject the model. They subconsciously were not appropriate. That's the key, the model.

Hughes: It really did work?

Gumbiner: It's worked very well.

Hughes: How successful were you in hiring people that actually stuck with the organization for a good number of years?

Gumbiner: We have had four doctors retire in the last year or two with fourteen to sixteen years service working in the organization.

We lose about a third of our doctors the first year or two, but after that hardly any.

Hughes: Why?

Gumbiner: Because no one is that good at picking, either picking people to work in an organization or people picking an organization they'd like to work for. A certain number of people will leave an organization for reasons you can't do anything about, such as their spouse may not like the area, they want to be in a rural area instead of an urban area, they thought they would like to practice with a group of doctors but found out they don't want to practice with a group of doctors, some changed their specialty (they didn't like being an internist any more and wanted to be a pathologist)--you name it.

Then there is a certain number of people you have to fire: their credentials are fine but they can't get along with humans; they have bad judgment. For example, they are a perfectly good surgeon and the procedures are done well, except they have bad judgment as to when they should operate.

Hughes: Whose decision was it to fire people?

Gumbiner: I was the CEO, medical director, operations officer, chief financial executive, and so forth, so it was my decision. I would call them in and say, "Doctor, we're not getting along and you don't seem to belong here. I'll be happy to accept your resignation. Just sign here."

Hughes: And it was usually as simple as that?

Gumbiner: Well, who wants to be around if they aren't wanted? Two people sued me, but I sued them back. [laughter] My general philosophy is, you sue me and I will sue you back. I usually lost because the courts decided mostly for the individual instead of the organization.

You should lose about a third of your new doctors in the first year or two. When you have a new person in a new situation, you don't know how they are going to get along; they don't know how they're going to like it; you don't know if they're going to succeed. Some people may succeed in one type of organization and not in another, and some were too immature. I really preferred doctors who had been in practice ten or fifteen years.

After doctors had been at FHP a couple of years, we would have about a 1 percent attrition. No one would ever leave after

the first couple of years. Early on, you shake out the people that are in the wrong place and they go down the road.

Hughes: What was the incentive to stay?

Gumbiner: People made more money each year and they got an increase in compensation. I developed a situation in which after five years they would get two months' sabbatical leave and a company car. Then I worked out a program where senior doctors had first choice of vacation time; after a certain number of years they didn't have to take call any more; they got the choice of working four days or five days (whichever they wished); they got more vacation (instead of two weeks they got four weeks and then six weeks); more postgraduate time--various little perks here and there. One of the biggest advantages, of course, was that they didn't have to build a practice and run a small entrepreneurial business.

Physician Salaries

Hughes: All along, were you offering competitive salaries?

Gumbiner: Well, I thought we were overpaying doctors, taking into account the risk reduction.

Hughes: That's not answering my question. [laughter]

Gumbiner: I'm answering your question. I don't know what a competitive salary is. You tell me: I'm making \$200,000 a year, I'm working every night, six to seven days a week, I have to take all the risk of building a practice (the funding), I have to do all the management, hire my nurses, and everything else, plus I can't take a vacation. Instead, I'm making \$100,000 a year, I only work one night a week, I get six weeks' vacation, two weeks postgraduate education payment, etc. Now tell me, what's a competitive salary?

Hughes: Yes, I see what you mean.

Gumbiner: Right now we're paying doctors about what they would make in private practice, plus they get all these benefits, both in cash and convenience.

Hughes: Why does FHP do that?

Gumbiner: I haven't got the slightest idea. I'm not running the place any more. [laughter] I'd cut their salary in an instant.

Hughes: You never gave doctors competitive salaries, plus benefits?

Gumbiner: Forget the word "competitive." No doctor knows what any other doctor makes. Most doctor salary surveys are inaccurate unless you factor in the value of the working conditions and benefits.

Hughes: Oh, there must be figures.

Gumbiner: Yes, doctors always lie about their income--always, 100 percent of the time. Number one, some of them get mixed up and quote you their gross revenue, not their net, or they'll quote you something that is mixed up with personal expenses. Sometimes they'll quote you the best month they had that year in revenue and then they'll extrapolate it for the year. There are all kinds of things like that. If money managers can dissect the truth, doctors certainly can.

Hughes: How did you set your salaries?

Gumbiner: How did I set our salaries? Oh, on a series of things. We can look the Medical Economics Journal and find out what people allegedly make and then adjust it for extra benefits. Then you can call around and see what the competitive salaries are for various specialties at other group practice prepayment organizations. This is one of the best ways.

Then, of course, there's a difference between a doctor just joining your group and a doctor who has been there for a number of years. I used to use the "star system" also. If the person was really a very popular doctor and was very competent, I would pay him a lot more.

Hughes: Why did you care, if you have a captive patient population?

Gumbiner: You don't really have a captive patient population because if you don't give good service, the whole group will disappear and go to some other organization.

Hughes: Were you the boss and the doctors were your employees?

Gumbiner: When we got into group practice prepayment and got rid of the medical group?

Hughes: Yes.

Gumbiner: Yes, I was the CEO and they were the employees.

Hughes: And they knew that?

Gumbiner: That's right. That was the model. [emphatically] That was the model.

Dr. Gumbiner as a Medical Practitioner

Hughes: Were you practicing any medicine yourself?

Gumbiner: In the beginning, when we were recruiting, I saw patients full time. Then for a while I was seeing patients Tuesday and Thursday evenings--mostly the patients that had difficulty getting along with the other doctors. Not that there were any difficult cases, they were just difficult patients.

Hughes: Why were you graced with these patients?

Gumbiner: Because I could get along with them by being more objective and taking more time.

Hughes: Could you?

Gumbiner: Yes, I would tell them, "I'm just your medical advisor. I can advise you what to do, but you don't have to do it."

Hughes: And that seemed to work?

Gumbiner: Well, for most people. Except once there was a famous guy that said, "I want my stomach out." I said, "Why do you want your stomach out?" He said, "Well, I drink a fifth of whisky every day and it makes my stomach hurt." [laughter] I said, "No, you're not going to have your stomach out. You're going to have to stop drinking a fifth of whisky every day." He said, "Drop dead," and then he left. The next thing I knew I had a call from some doctor who had hospitalized this guy and was asking for my x-rays because he was going to take his stomach out.

Hughes: Oh, come on!

Gumbiner: That's right. He got paid for it. The guy probably quit drinking whisky if his stomach was taken out. [laughter]

Hughes: Did you consider yourself a good doctor?

Gumbiner: Yes, I was a very good doctor. I never got sued in my whole life, in twenty years, never had anybody even think about it,

and I never released a patient from a hospital in my life that I didn't personally see.

Hughes: Why did you give it all up?

Gumbiner: Boring. It was boring as hell. [loudly] Boring! If I had to see another person complain of a backache or a headache, I would give up. It's just boring! A lot of good doctors change after ten years or so and either go into super-specialty, join a group, go into management, or go into another field.

Hughes: So you don't miss medicine?

Gumbiner: Absolutely not. It's also depressing. How would you like to spend all your day talking only to people who complained? They all complained. No one comes in and says, "Doctor, I've just come to tell you I feel wonderful!" [laughter] They either complain about themselves or somebody else.

In the 1960s the competition from other group practice prepayments wasn't a problem. The main problem was the fee-for-service sector, not just the doctors but the whole fee-for-service sector trying to get rid of us.

Hughes: How specifically were they going about that?

Gumbiner: They wouldn't give us hospital privileges, they tried to drive our doctors away by not giving them surgical privileges, they would bad-mouth us, telling anyone who would listen that we hired bad doctors, we were unethical, we must be crooks, we discriminated against our people, et cetera.

I had to hire physicians who were independently minded, who weren't bothered that they weren't socially acceptable among their peer group, but at the same time were flexible enough that they could work in an organization were they weren't the boss. So, if you were to give somebody a FIRO [Fundamental Interpersonal Relations Orientation] test, they'd have to score somewhere in the middle on their need system of belonging and somewhere in the middle on their need system to control.

Hughes: Did you actually give the test?

Gumbiner: I didn't give the test, but I knew what it was all about.

Hughes: Was there a Family Health Program physician type?

Gumbiner: No, I don't think there was any particular type. If I had to say there was a type, it would be a type that was more

altruistic than the average physician, less money-oriented, and less geared to ostentation. I've got a theory that the ostentation of many physicians stems from boredom with their profession. Most people are achievement-oriented in some way or another, and if you're doing the same thing over and over again every single day, what are you going to achieve? Well, you can achieve a bigger house, a bigger car, send your kids to fancy schools, join a fancier country club, improve your self image, et cetera.

Hughes: Most physicians look upon themselves as very hard-working compared to the rest of the world.

Gumbiner: They're not any harder working than most managers, I'll tell you that.

Hughes: Yes, but I think the perception is there.

Gumbiner: Well, they're harder working than college professors.

Hughes: I'm talking about their own perception of what they're doing.

Gumbiner: Most of them are scared to death, and that's why they have this godlike perception of themselves.

Hughes: Well, explain that one to me.

Gumbiner: Most of them are frightened to death: "Did I really give the patient the right thing? Did I really do the right thing?" They have to feel that they did the right thing.

Hughes: So they put up a facade?

Gumbiner: Well, they do other things such as overcompensating through arrogance or control.

Marketing to Medium-Sized Patient Groups

Hughes: Was there any deliberate attempt on the part of FHP to cultivate a different patient population than the one Kaiser was marketing to?

Gumbiner: Yes, Kaiser had already been strong in unions and with government workers. We also went after government workers and school districts but in a different geographic area (i.e., Long Beach and Orange County), as well as the small or medium-sized

group market. For example, we developed the first prepaid program (Medi-Cal) for the poor in California.

Hughes: Was that at least partially because Kaiser wasn't doing Medi-Cal?

Gumbiner: Nope. When you look at the market, most employers are in the medium-sized groups (100 to 1,000), and Medi-Cal allowed for more diversification.

Hughes: Was that a sizeable source of your revenue?

Gumbiner: It's still a sizeable portion of our revenue.

Hughes: Could an individual belong to FHP?

Gumbiner: No, we soon figured out after that first group of individuals that we couldn't underwrite individuals.

Hughes: Why?

Gumbiner: Because you'd get adverse selection by the sick people joining you. You'd ask, "Well, how about Medicare? Those are individuals." Except that there, the payment is made for them by someone else, i.e., the Social Security Administration. But when an individual has to pay for health care out of his own pocket, you'll find that mostly just the sick people are willing to pay for it out of their pockets. People who don't get sick very often, or don't think they're going to get sick, won't join your program because payment of health care premiums is not a priority.

Hughes: You found that when you solicited middle-sized businesses that the patient population balanced out?

Gumbiner: No, you're missing the point. The point is, I'm talking about individuals.

Hughes: Yes, I know you are.

Gumbiner: I said you can't underwrite individuals because you get selected against.

Hughes: Right, but I think my train of thought is logical: one reason you moved into the middle-sized business groups is because you didn't have skewing towards very sick patients.

Gumbiner: Right, that's the reason we moved into any group, be it a school district, a city, or whatever. You go into a group

because everybody in the group is part of the program and the employer pays for all or part of the premium, so you get everybody; you get the sick as well as the partially sick and well. Thus, those that are not sick pay for the sick--a basic insurance concept.

The big problem comes when you have a dual choice between an insurance indemnity program and an HMO. There's always an argument that the HMO takes all the well people, leaving the sick people for the insurance company. This is not true. For example, the HMO benefits for maternity are so much better than those of the average insurance company that we get most of the maternity cases and, as a result, most of the expensive neonatology. Maternity cases are reasonably elective, and the big expense cases now are newborns since an intensive care newborn nursery costs \$2,000 a day. Or if you have to do a liver transplant it might cost you \$500,000. So, that's where the difference in utilization is.

Nowadays, however, we take the whole group whether or not it's on our insurance company or our HMO. We just spread the risk among everybody through both FHP indemnity insurance and the HMO.

Hughes: You make no attempt to assess what the medical needs of a particular group are?

Gumbiner: Oh, we can't do that. As a federally qualified HMO, we have to take anybody out of the group.

Hughes: Before that HMO qualification came in, did you make any attempts to assess a group's medical needs?

Gumbiner: No. On the contrary, we used to have what we call "community rating" where we gave the same rate to every group no matter what the ages or the medical condition of the people in the group were. Community rating put us at a big disadvantage with the insurance companies who used to do what they called "experience rating." They would rate the care according to age, sex, and health condition. If you had a higher age population with more women, they would charge them more. They were doing this while we were using community rating and charging everybody the same.

Hughes: And that was true of all HMOs?

Gumbiner: Right.

Central Medical Center, Long Beach, 1967

Hughes: In 1967 you opened a second medical center which was Central Medical in downtown Long Beach. Why did that come about?

Gumbiner: I did a demographic study regarding the downtown Long Beach area because I wanted to place a center that would appeal to the middle class, the affluent people along the ocean, as well as the low-income Medi-Cal people, plus the Medicare population. I found several appropriate locations but narrowed it down to an old warehouse on Alamitos and 5th streets that was located on an odd triangular piece of property, which made it affordable as I had very little money. Then I had all kinds of problems getting it built: site, architectural, and cost-factor problems.

The first big boost that we got in that area was when I developed the first prepaid program for Medicaid, which was called Medi-Cal in the state of California. Title XIX (the Medicaid program) was passed, along with Title XVIII (the Medicare program), in 1966. When the AMA lost its lobby against Medicare in 1966, it turned around and decided it would be for something for a change, so they supported Title XIX, which was care for the poor. This was a pretty dumb thing they did since it caused the doctors and hospitals more problems than they had with Medicare.

Hughes: Why was it dumb?

Gumbiner: Because the Medicaid program, or Title XIX, couldn't survive since the politicians wouldn't put any money into it because the poor don't have any power. Thus, the doctors and hospitals were paid less and less under that program.

Hughes: And the poor don't vote.

Gumbiner: That's right. Now, you've got it. So therefore the poor don't get care, right?

Hughes: Right.

Gumbiner: Besides, doctors don't like to care for poor people; they don't smell good and they don't talk right.

Hughes: It's a very just system.

Gumbiner: What?

Hughes: I'm being sarcastic.

Gumbiner: A two-tiered system, right?

Hughes: Right.

Gumbiner: Anyway, I developed the Medi-Cal program. It took me two years of writing Sacramento, of going there and talking to various people, testifying, and so forth to get that first pilot project for the prepayment of Medi-Cal in California started.

So, I opened up this center in downtown Long Beach on Alamitos and 5th streets, which was right on the edge of the ghetto, but also on the edge of the affluent area. I had the idea that I could treat both population segments in one place, and for a while I did.

Hughes: Using the same facilities for each population?

Gumbiner: Yes. When I hired my first black doctor, there were people who told me that the white folks wouldn't go to a black doctor. It turned out they were wrong and the white consumers were just fine about it.

Lobbying for the Medi-Cal Pilot Project

Gumbiner: Fee-for-service payment for Medi-Cal couldn't work because what you had was a finite amount of money--the feds would match the states--and an infinite amount of care. Medi-Cal is unworkable because it's the payer of last resort in long-term care, and as more people stack up in long-term care and don't die, it uses up more of the finite amount of money.

Hughes: Why did you get into it then?

Gumbiner: Well, I decided that the only way it could work would be through prepayment where the government could budget the limited funding by agreeing to prepay a certain amount to cover a certain number of people for all services.

In about 1968 a California assemblyman named Gordon Duffy, who was chairman of the assembly health committee, which was a very powerful position in health care, passed legislation calling for an innovative approach to solving the Medi-Cal problem of cost overruns and access. I testified before his committee a couple of times, indicating that I thought prepayment was the only way to solve the problem. I kept

writing to him, writing to the head of the health department, and going to Sacramento concerning this problem.

After contacting someone in Sacramento every month for about two years, I happened to be in Sacramento on a Thursday afternoon and went to see my own assemblyman, James Hayes, whom I had met in Long Beach when he was vice mayor.

So I made another trip to Sacramento in the spring, when they weren't doing too much, and I happened to get lucky. I said, "Jim, I've got this big pile of communication and I've been coming to Sacramento for two years about a solution to the Medi-Cal problem. I want to get somebody to listen to me but they don't want to listen." He said, "Well, why don't we go see Gordon Duffy, who is chairman of the assembly health committee." I had never met Gordon Duffy before in my life but I said, "Okay," and went over to see him. I said, "Look, I've got this big pile of communication, I've testified, I've been up here several times, and I've talked to people but no one will listen to me." He said, "That's really strange. I've got this bill up and it seems that nobody is paying any attention to it." He then called up the man who was head of the Department of Health in those days, Carl Mulder, or something like that. Ronald Reagan was governor then and the health department was in a storefront, which shows you how under-managed it was. It was probably a twenty-minute walk from the Capitol building.

Gordon Duffy called this man up and said, "I've got a man in my office here who's got what I think is an interesting suggestion to solve the Medi-Cal problem and I want you to talk to him about it. If you don't do something about this I'm going to go to the corner office [the governor's office]." There was silence and Duffy said, "When did you say you can see him? Twenty minutes? Fine." I walked over to where this man was sitting (I had never met him before either). He said, "Dr. Gumbiner, we've read over your proposal and we think it has great merit." After two years of doing nothing he suddenly saw the light! He further said, "We think we can put this together. When do you want to do it?" It was then spring and I said, "Well, I think we can put it together in four or five months, perhaps by October."

Hughes: What was your proposal?

Gumbiner: My proposal was for FHP to do a prepayment pilot project--to enroll 6,000 people that were covered by Medi-Cal and provide all the services for one set fee per month that the state was supposed to provide. We wanted to provide doctors' services, hospital services, mental health services, prescription drug

services, and preventive services. We were the first one in the country to ever do that. Health Insurance Plan of New York [HIP] had done something like this but just for doctors' services.

Hughes: Those services were mandated by the state?

Gumbiner: The state had the choice of offering certain levels of services and the feds would match dollar for dollar. Basically, they only had to offer doctor, hospital, and prescription drugs. They didn't have to offer preventive service, mental health, or anything else. The state of California decided to offer all these services, but then they found out they couldn't pay for them.

Enrolling Patients

Gumbiner: We offered to supply all services for one set amount which we calculated we could do. Well, it worked fine and we did provide these services, but we had a hard time enrolling people. You'd think, gee, why wouldn't people enroll? Here we offer access, we're open seven days a week, and everything was covered. Poor people, however, don't communicate by reading, they don't understand things, they're very suspicious of something that is new, and they have other priorities.

Hughes: How did you get around the problem of enrolling people?

Gumbiner: Well, I found out that I had to sell it. At first people would say, "Oh, you provide all the health care services for one flat amount and people will take it away from you." It had to be explained. We went through a whole series of different approaches.

First we tried to get community representatives (poor people who worked and lived in the community). They didn't know how to sell anything. First of all, they didn't like to get out of bed, they didn't know how to work very hard (that's why some of them were poor), and their communication skills were poor. We finally went to just plain old hard-working professional door-to-door salesmen who could sell the concept. They would say, "This program is good for you; you get all these services; the medical center is nearby. Just sign here." We finally enrolled a number of people.

The first group of 6,000 we tried in Long Beach which worked out pretty well. They got the care, we made a reasonable amount of money, and the state saved money. The state legislative analyst--I think his name was [A.] Alan Post--evaluated this program for the state of California and came up with the statement that we were supplying care for 25 percent less that was as good quality, if not better, than the fee-for-service sector.

Hughes: Did that make an impression?

Gumbiner: Yes, that made an impression. Then we enrolled another 6,000 in the Compton/Watts area. We bought a building in Compton, remodeled it, and opened up the Compton Center.

We enrolled another 6,000 in Orange County. Governor Reagan and his group decided that this was such a wonderful program that they should open it up to any organization which wanted to provide it. However, organizations got into the program that were just opening up with storefront clinics and were not providing the care. This was referred to as the Medi-Cal scandal of the 1970s.

Hughes: But initially you were the only HMO in the game.

Gumbiner: You've got it. When the idea of a prepayment program was first conceived, I was invited to Sacramento to discuss it. There was a representative from Kaiser, five or six insurance companies, and Blue Cross. The state officials said, "Which of you organizations want to participate in this program?" Kaiser said, "We can't do it. We don't have enough beds." The insurance companies said, "We need six years to study it." Blue Cross said, "We just don't like it." So I said, "We'll do it. I've got ten doctors in our group and we'll do it."

Hughes: Was ten doctors enough?

Gumbiner: Yes, since we were not supplying all of the Medi-Cal medical services through these doctors but were also paying outside specialists. I had it figured at the same rate as the general population. What I didn't know, but learned later, was that poor people, instead of using a half a visit per month per person, use about two-tenths of a visit. They don't recognize an illness when they have it so they never show up. There is no health education, they don't have transportation, so they under-utilize, plus the fact they're very suspicious. ^{then} But as you meet their unmet health needs and they become better educated to the availability and necessity of health care, their utilization goes up. Pretty soon, instead of having two-tenths of a visit

per month per person, they have eight-tenths of a visit and exceed the general population.

Hughes: Because they have more health problems?

Gumbiner: That's right. In the beginning you never see them; you can't get them to come in. It's not a question of them rushing in, it's a question of trying to educate them to come in before they get very sick.

Hughes: In your book you describe, and I quote, "The going was pretty hot and heavy at times..." at the meetings with Medi-Cal recipients when FHP was starting the Medi-Cal program.¹ Was there dissention within FHP about taking on Medi-Cal?

Gumbiner: Doctors actually don't like to take care of poor people.

Hughes: It was just as simple as that?

Gumbiner: Doctors don't like to take care of poor people; it's as simple as that. Doctors are, in general, upper middle-class white people, particularly now that it costs you \$25,000 a year for medical school tuition. Sometimes they're black people trying to get the hell out of the ghetto.

Hughes: And doctors used to be almost exclusively male.

Gumbiner: Right. In general, poor people are hard to take care of. First of all, they only have a 1,000- to 2,000-word vocabulary, or whatever it is; they usually are not dressed very well, they don't smell too good, they have lots of bad problems, you can't understand what they're saying, they have lots of kids running around, and some of them are crazy. Remember, under Medi-Cal you have Aid to Families with Dependent Children [AFDC], Aid to the Blind [AB], the aged, and the crazies.

Hughes: And you were serving all those groups?

Gumbiner: Yes, we had to serve all those groups. We couldn't just pick and choose.

¹Robert Gumbiner, M.D. HMO: Putting It All Together. St. Louis: The C.V. Mosby Co., 1975, p. 120.

Establishing Dental (1970) and Psychiatric (1971) Services

Hughes: Were you offering psychiatric care?

Gumbiner: Yes, mostly through psychiatric social workers coordinating with a psychiatrist. We put in a social workers division to do the group therapy and routine family counseling.

Hughes: Because of Medi-Cal?

Gumbiner: In the beginning, yes, because Medi-Cal was the only program that had that benefit. Medi-Cal got us into the dental business also. When we were about six months into the program, people came in from the state Department of Health and said, "Where's the dental program?" I said, "What dental program?" They said, "The dental program you're supposed to have." I said, "The contract doesn't call for a dental program; I read it over." They said, "Yes, but we're paying for a dental program and you're supposed to have a dental program." (Somebody had made a mistake and didn't put it in the contract.) I said, "I don't know anything about a dental program." They said, "You've got to have a dental program."

Hughes: Could you have said no?

Gumbiner: No, they said you have to have dental coverage. They were very embarrassed that it had not been written in the contract and when bureaucrats get caught making a big mistake, they get frantic. So I said, "Well, when do I have to have a dental program?" They said, "Next month." [laughter] I said, "Well, let's think about this a minute."

As I recall, I called a friend of mine with a big dental office who had offered the first prepaid dental program to culinary workers. He knew all about prepaid dental programs but he wasn't in the prepaid business any longer. He had offices about four or five blocks from us and they must have had about twelve chairs in them. He was just rattling around in there by himself. So I said, "Let's make a deal. You put in a dental program and I'll pay 90 percent of the premium," or whatever deal we made. We got together, put a dental program together, and went on down the road. By the time he started to overcharge us, I had figured out how the dental program worked and put one in myself.

Hughes: How did you get dentists?

Gumbiner: Well, it was very difficult. I had to hire a dental director.

Hughes: He was a dentist himself?

Gumbiner: Yes. The first couple of dental directors I got were pretty bad since I didn't know what I was looking for. Finally, as the role became more clearly defined, I found the right person.

Hughes: Now this program was just for the Medi-Cal patients?

Gumbiner: Yes.

Hughes: But not forever.

Gumbiner: No, as soon as we figured out how to organize and make the dental program work, we made it available to the rest of our programs.

Hughes: Well, that was a lucky stroke.

Gumbiner: Actually, it was fortuitous. It wasn't as if we'd planned to have a mental health program or a dental program, we were forced into them, but once we were forced into them, we figured out we could do them.

Hughes: Well, I would think that giving psychiatric services is quite a different thing than providing medical care.

Gumbiner: We only had to do short-term psychiatric. We were not responsible for long-term care.

Hughes: So a patient could see a doctor a certain number of times and then no more?

Gumbiner: No, we were treating immediate emotional problems of coping in the here and now, not long-term analysis. We had a group of psychiatric social workers who did the primary group therapy work on a one-to-one basis. The psychiatrists did the difficult cases, consulted with the social workers, and did the drug therapy (we didn't have much drug therapy then). For a period of time we used part-time psychiatrists who came in and consulted with our full-time psychiatric social workers; you don't need a psychiatrist to treat people for the usual emotional problems.

Hughes: Is that the way you operate today?

Gumbiner: No, unfortunately we have four or five full-time psychiatrists.

Hughes: Why do you say unfortunately?

Gumbiner: Psychiatrists in general are not very good managers. For a long time we had this back and forth debate as to who was going to manage the department--the social workers, the director, or the psychiatrists. Frankly, I don't what they're doing now. I know that we used to have a number of patients in the mental hospital when we did not have our own psychiatrist, but as soon as we got our own psychiatric service suddenly it seemed like only about one-fourth of the cases needed hospitalization. That's how psychiatrists making their living; they visit a bunch of people in the hospital, fifteen minutes each, if it's fee-for-service.

Testimony Before a Committee of the California Assembly, 1971

[Interview 3: December 12, 1991] ##

Hughes: In 1971 you testified before the California Assembly, or a committee thereof, about the success of the Medi-Cal pilot project, which was investigating Medi-Cal cuts.¹ I was wondering what you said and what the reaction of the committee members was.

Gumbiner: I don't recall what I said in 1971.

Hughes: Well, do you recall the pilot project and whether it was a success or not?

Gumbiner: Yes, I recall that. I testified that we were bringing all these medical health care services to beneficiaries for one set price per month per person. Fundamentally, we were giving them access to complete care without charge, and we were giving it to them in a local area. I said that we probably saved the state of California 25 percent compared to what they were spending on other Medi-Cal sources, and that the quality was as good, if not better.

Hughes: What happened after you gave the report? Did they adopt any of the principles that you had been trying out?

Gumbiner: I don't understand your question. It wasn't up to the committee to adopt any principles. All they were doing was conducting a legislative overview. You have to remember, the legislature doesn't manage anything. All the legislature does is make laws. The executive branch of the government does things. All the

¹FHP Newsletter, January, 1971.

legislative branch can do is have hearings and pass legislation encouraging things to happen, but nothing happens until the executive branch decides to make it happen.

Hughes: Yes, that I understand, but they could have modified the existing laws or passed new ones if you had come up with something startling.

Gumbiner: They didn't do anything. However, the executive branch did something. Remember, all the legislative branch does is make legislation and approve budgets, things of that nature, but they have a working relationship with the executive branch. The executive branch, of course, manages a bureaucracy, but the legislative branch influences that bureaucracy by either approving its budgets or not approving its budgets.

So what happened in that instance was, the executive branch under the Reagan administration decided that the provision of care for Medi-Cal beneficiaries through risk contracts was the way to go because they were having so much trouble with the fee-for-service sector exploiting the system by overbilling and billing for things that it didn't do. Because of the lack of access, the executive branch decided the best way to do it would be to have the whole thing in the hands of the HMOs, which at that time were called Group Practice Prepayment Plans. Actually, when Reagan left office he wrote a letter to Jerry Brown, which I've never seen but allegedly exists, advising him that when he took office to turn the whole Medi-Cal mess over to organized prepayment programs and let them handle it.

Anyway, Reagan was so enamored with this that he gave instructions to his people to try to get the whole thing into group practice prepayment, whereupon a number of operators sprang up and began enrolling these Medi-Cal people, using all kinds of tactics to do so. Whether this is true or not, that was the accusation.

I had to remove the individual from FHP who was in charge of enrolling our Medi-Cal sector because he was uncontrollable. I told him we only wanted 6,000 individuals in the pilot project in Long Beach, we wanted 6,000 individuals in Watts/Compton, and we wanted 6,000 individuals in the Orange County area. He kept enrolling more and more, and I knew we shouldn't enroll a group of people we couldn't take care of.

Anyway, there were other operators, particularly one called HMOI (I think that was the name of it). They hired the guy that I had let go and decided they would enroll any number of patients they could. They went throughout the Watts/Central Los

Angeles area and enrolled a huge number of people and, of course, they weren't able to provide care for them, despite the fact they had all those storefront offices that they were attempting to man. I don't know that you'd call it a scandal but it caused a lot of complaints.

What happened is that the congressmen and the bureaucrats listened to all these horror stories. After a few complaints they got very frightened, had a knee-jerk reaction, and tended to destroy some of the best things ever created.

Advisory Committee on Prepaid Health Plans, 1975

Gumbiner: When Jerry Brown came into office as governor, the policy of taking care of Medi-Cal was to appoint ethnic minorities-- whether they were competent or not didn't make any difference. During that period of time I was on the Advisory Committee on Prepaid Health Plans of the health department (which was a pretty good committee), but we had some turkey of a guy that was the administrator of that committee. We finally got rid of him but then he got rid of the committee. Then subsequent to that, I was on the State of California Health Advisory Council (1975-1977), which was an advisory committee to the governor. That committee eventually deteriorated into a State Certificate of Need committee.

At that time, in order to build a hospital, any hospital, you had to present a certificate application to a regional board. The regional board would decide whether or not that area had enough hospital beds. If denied, they could appeal the decision to the State Certificate of Need Board and that was what this committee finally became. The problem was, the number of beds in a region was not evaluated as to quality--a hospital ready for the bulldozer was equal to a first class institution.

When I first served on the committee they had some reasonably knowledgeable people on it from the hospital industry, the AMA, and the HMO industry. Under Jerry Brown it deteriorated. One guy, an American Indian, sat there through all the meetings covered with American Indian paraphernalia and didn't say anything. Then there was a black woman doctor who never said anything except "no." She would vote against everything if she didn't understand it. And there were several other people that didn't know what they were talking about but who were there strictly because they represented some ethnic minority.

For instance, there was one meeting I walked into a little bit late and somebody was haranguing that they should get rid of this one certificate of need organization in central Los Angeles. I had never heard anything about this before and they were about to vote on it. I said, "What are you talking about? What's the charge?" They said, "Well, the charge is that these people had sixty applications for an executive director and after they had culled through about thirty or forty of them, they made their selection without seeing all sixty." I said, "So what, if he was the best person?" (They had selected a consultant as the associate director.) The committee was about to void \$2 million worth of effort by this local organization on the basis of a few allegations. I then made a motion that we table the issue because I hadn't had a chance to look at it; I didn't know what it was all about and neither did anybody else. The vote was four to three to okay my motion but the chairman said, "I move to tie the vote, so your motion fails." Of course, in Robert's Rules of Order nothing like that exists, but if I had appealed to the chair, he'd have done the same thing. But that's the kind of shenanigans that were going on on that end.

Meanwhile, in the Medi-Cal setting, Jerry Brown had appointed a Hispanic attorney as secretary of health. The legislature voted that this guy (I forget his name) was the worst cabinet member that had ever existed. He knew nothing and was there merely because he represented the Hispanic community. He was later dragged up to Washington and fished for the way the California Department of Health was supervising Medi-Cal. At that same time our Medi-Cal contract was up for renewal. Every year the state renews its Medi-Cal contracts.

Hughes: Automatically?

Gumbiner: Not automatically but usually, because we were providing care and saving them money. We were known as the most outstanding Medi-Cal contractor the state had.

Hughes: Were they thinking of price?

Gumbiner: No, performance--and providing the best care. Every Medi-Cal contractor had the same price and we would negotiate rates every year, but we all got paid the same.

Testimony Before the Senate Permanent Subcommittee on
Investigations, 1976

Gumbiner: The next thing I knew I had somebody from Washington, D.C., down here, an aide to Senator Nunn. At that time Senator Sam Nunn was a junior senator from Georgia trying to make a name for himself.

There was a really great lobbyist who would call me every once in a while and say, "There's some aide around that's going to try and cause trouble for people who are providing Medi-Cal services." I then called Group Health Association of America [GHAA], the HMO trade association on whose executive committee and board of directors I served, and said, "What do you think I ought to do about this?" They said, "Oh, we know you're a good guy, just go ahead and tell the truth."

I dutifully went to Washington and walked into this committee room at nine o'clock in the morning. There were two television cameras and about eight reporters on hand. I said, "Wow, it looks like I've been sandbagged here." They called up people from HMOI and Don Kelly, who was the doctor who started it. Kelly got up and took the Fifth [Amendment], while the other people stood up and said, "He's the bad guy. We've reorganized and thrown him out and now we're going to do good things." [laughter] They were the guys that were causing all the trouble.

I went back to Washington with Andrew Campbell, my chief financial officer, but I didn't have an attorney with me because I didn't know any better. However, the trade association [GHAA] people should have known better. The committee asked me all kinds of questions, all of which were either unfounded allegations, misinterpretations, or entrapment lies. They dragged up a so-called "health department examiner" who claimed he'd been observing in our centers. No one in our organization had ever seen this man before anywhere in our organization, which made me believe he never was there. He made statements like, "Somebody put up a blackboard saying, 'Do as little as you can for the Medi-Cal patients.'" The committee said, "Do you know what group that was?" Of course he didn't name the group but the inference was that it was us, which it was not. Even Senator Nunn was a little astounded and didn't believe it. What he had there were three aides who kept passing him questions, himself, and no other senators.

In a senate hearing like that, the senate committee is the prosecutor, the judge, and the jury. Their typical modis

operandi, if they want to fry someone, is to call him up in the morning, ask the witness a bunch of surprise questions the witness doesn't know the answers to, and try to trip him up. They call someone else up in the afternoon to say that the previous witness is a liar or doesn't know what he's talking about. Of course, there's no way to object, no way to cross examine, or anything else. So this was a real star chamber.

I was smart enough to tell them I didn't know what they were talking about. They would bring up things like, "Here's a form where somebody was disenrolled in your program because he was in a nursing home and there's no signature on it." Senator Nunn at that point said, "How can they disenroll if there's no signature?" They would say, "But that's what they're doing, they're disenrolling the sick people." As it turned out, we had a contract that we could only care for people who were cash-grant recipients. In other words, they got their health care and then they got a cash grant to live on. When they went into the nursing home, the nursing home took the cash grant because they were now living in the nursing home and by contract they were no longer eligible for our program. So the nursing home would automatically disenroll them by sending in a form to the health department.

I told them, "I don't know what you're talking about. Just keep the record open and I'll send you all the information you want when I investigate the accusation." They said, "We think you're making all kinds of money out of this program." I said, "I made \$60,000 last year and I'll send you my W2 statement." They said, "We don't want your W2." In other words, they didn't want facts to disturb their preconceived game plan.

When I returned from that trip, I put some of my management trainees on preparing answers to those allegations. We sent them back a big thick book of facts and exhibits refuting everything that these people had accused us of. Once we did that the investigative report just had to sit there because now they couldn't publish the accusations without including our book of answers and analyses. They were absolutely furious because their scheme had backfired.

I rattled around, got a Washington attorney, and said, "Why don't you go talk to this committee?" So he talked to them and he said to me, "Just withdraw that whole book of evidence that you gave to them and write them a simple letter saying you don't do things like that and you never did things like that, and they'll agree to drop the case. Forget it, because they have all the time in the world and will keep hassling you for years."

Well, we weren't a big operation in those days and didn't have a lot of money to spend on litigation, so I agreed to do that.

Suit over Medi-Cal by the California State Attorney General's Office, 1977

Gumbiner: Meanwhile, in the back of the room was a young deputy district attorney, Swartz, for the state of California madly taking down the allegations on a note pad. Shortly after that, this deputy district attorney filed a suit against the company and the board of directors. But--get this--first he notified the local papers. After that, on the Friday before Labor Day, he filed the papers so that I was never served but the newspaper got the filing from him. We didn't even know what the suit was about, but we got bad headlines with no chance for comment.

Hughes: Charging what?

Gumbiner: He was charging all the unfounded accusations made in the senate hearings, which were only calculated to get notoriety for Senator Nunn, which Nunn didn't get. Nunn's aide was very stupid and had subpoenaed another case (a congressman), so Senator Nunn fired the aide, as well as the whole gang. That didn't help us, however.

Meanwhile, the deputy district attorney sued us as a result of those bogus charges. At that time [1977] the attorney general's case was based on the following: no one could finance a fledgling staff model HMO. No bank was going to lend money for a medical building that was built specifically for an HMO group practice, a nonprofit organization for which there were no grantors, particularly in a new, unknown field that all of the medical experts said would fail. There was nothing useful for the bank to repossess as the HMO was a nonprofit organization. The problem was in financing a specialized medical group practice prepayment building, and the only people who believed that this could be successful were ourselves.

For each building we built, we set up a limited partnership in which we would ask the doctors, managers, board of directors, or anybody else we could find, to contribute money and buy shares of the partnership. The limited partnership would then build the building comparable to other office space in the area. The HMO had a friendly landlord and got the building built. The partnership came out all right because it had a tenant (but only if the HMO succeeded), and if the HMO tenant could not pay the

rent, the HMO was not evicted. So it worked out fine for everybody. The question of why the HMO did not rent other space was moot because there was no other space to rent that was in the areas we wanted, nor were they built for an HMO.

The young staffers in the deputy district attorney's office decided there must be something wrong with this process and we were accused of some way getting money from the HMO illegally, which was not true. Everything was disclosed fair and equitably, and the partnerships were underpaid for the risk, if anything. However, we had to settle with the attorney general because we didn't have any money to litigate this case at that time. We were forced into a very punitive type of settlement in which all the limited partnerships had to sell the buildings back to the HMO at a big discount and loss to them.

The HMO had enough money that it could buy back some of these buildings but couldn't litigate for two or three years. There were some buildings it couldn't buy back because it didn't have the money. The partnerships had to lease these buildings at a very low rate and agree to options without remuneration.¹

Suit over For-Profit Conversion by the California State Attorney General's Office, 1985

Gumbiner: Fifteen years later that same deputy district attorney sued us when he first attempted to enjoin us from converting to for-profit, mistakenly alleging that he had to approve the conversion. He claimed that we were converting for an inadequate price. However, we were converting for a price that Ernst & Whinney, one of the Big Eight accounting firms, had evaluated and which the corporate commissioner had agreed was an appropriate price. His was an exercise in futility since if he [the deputy district attorney] had prevailed we simply would not have gone forward with the conversion. Plus the fact, a not-for-profit organization is worth x but when it goes public it may be worth something more, depending upon where the market is at that time. Of course the company can convert but it may never become public, or five years later it may be worth even more. As the corporate commissioner testified, "It's like selling your house. One year or two years later when it's worth

¹[Dr. Gumbiner added the following footnote during the editing process:] If I had been more experienced, I would have had this assistant district attorney cited for unethical conduct.

a lot more money than you sold it for, you want to go back and sue the buyer and tell him to pay you what the house is worth today."

The second time that same deputy attorney general sued us we had a lot more resources and hired a big law firm. The attorney general lost the injunction but appealed it. However, he lost in the superior court and in the circuit court of appeals. He lost all the way down the line, four times. We were able to prove that he had no standing whatsoever in this case, that he was wrong in theory, so he finally gave up. But he caused us a whole lot of trouble. However, as a result of the first suit, the then secretary of health in the state of California, Mario Obledo, got very frightened and there was a question of whether he was going to renew our original Medi-Cal contract.

I went to Sacramento and talked to the man who was head of the department of health and he unequivocally, upon the advice of his people, recommended that our contract be renewed. After a meeting with five assemblymen who supported us, this secretary of health did not renew our contract, alleging that no one was to "point a finger at him." At that point, we attempted to enjoin the state of California. We made a big mistake by having a big law firm because it provided a big thick brief on the injunction, which was useless. You shouldn't do that; you should produce a thin and to-the-point brief.

Hughes: Why?

Gumbiner: Because the judge reviewing the injunction only has a very short time to look at it. If you've got a big thick brief, he doesn't look at it at all. Of course, the legal firm gets paid by the pound and that's why it does that.

Hughes: Doesn't it like to win its cases?

Gumbiner: Well, given winning its cases or making a lot of money, it prefers to make a lot of money. [laughter]

Anyway, over the weekend we lost 50 percent of our gross revenue through the loss of our Medi-Cal contract. That was the second trying time. The first trying time was when all my partners walked out in 1966. Notwithstanding, six months later they were back asking us to take back a Medi-Cal contract.

Hughes: Why?

Gumbiner: Why? Because we did a good job and we supplied a valuable service. They crucified us to get away from the heat. Later, the secretary of health was fired and there was a return to reality. But in the meantime, we had to scramble around to make up for the loss of the Medi-Cal contract. Actually, we cut back in a lot of places and in something like four to six months we were back to the where we had been in terms of revenues.

Hughes: What percentage of revenues had Medi-Cal been?

Gumbiner: Our Medi-Cal had been about 50 percent of our gross revenues.

Hughes: So loss of the contract was quite a worry.

Gumbiner: Well, it was a challenge, you might say. [laughter] Fortunately, I had a good strong management team and we were able to overcome this. The most important thing in any situation is the depth of your management team. I can tell you how we did it in a few words, but basically it was just good management: cutting back on the overhead, streamlining operations, and increasing marketing and advertising.

We moved along in 1977, got over that problem, and continued to expand through Orange County during the late seventies and early eighties until we developed the Medicare program.

Hughes: In 1966 you consulted with the Social Security Administration about how group practice prepayment programs would work in conjunction with Medicare.

Gumbiner: In 1966 we went into what you call a cost contract where we only provided doctors' care. We did not provide hospital care, prescription drugs, or preventive care.

Group Health Association of America ##

Chairman, Membership Committee, 1972-1976

Gumbiner: I got involved with the Group Health Association of America. First I was chairman of its membership committee, which tried to get group practice prepayment organizations into the association. I discovered soon that they didn't have any criteria to belong, so then I suddenly found myself on a

committee that met all over the country to set up criteria for membership. I chaired the membership committee for about four years.

Hughes: Did the membership go up?

Gumbiner: It grew quite a bit, but I wouldn't let any organization in that didn't ascribe to the criteria. A few people in the organization wanted their favorite organizations in there, even though they wouldn't qualify. I was then shipped over to the chairmanship of the bylaws committee.

Kaiser Permanente's Role

Hughes: Kaiser did not belong to the GHAA for a number of years, I understand.¹

Gumbiner: Kaiser was the elephant in the tent. Kaiser controlled the whole thing.

Hughes: How?

Gumbiner: Easy, they just filled all the committees and served as the important committee chairmen.

Hughes: But Kaiser was a member for many years.

Gumbiner: No, for a long time only the Permanente Medical Groups were members. Kaiser kept trying to straddle both worlds; kept trying to be the good guys. Their Permanente doctors were frightened that they would be ostracized from the medical community, so they kept trying to "kiss up" to the medical establishment. And at that same time they were trying to be pioneers, which doesn't work well.

¹For more on Kaiser Permanente's role in the Group Health Association, see the Regional Oral History Office interviews with Scott Fleming (in progress), which are part of the series on the History of the Kaiser Permanente Medical Care Program.

- Hughes: They were ostracized by the medical establishment in the early days.¹ It was a fait accompli.
- Gumbiner: Ah, but they kept crawling back into the medical establishment organization; they kept crawling in one way or the other.
[laughter]
- Hughes: What are you saying? That they were stacking the committees?
- Gumbiner: Yes, they stacked all the committees in the trade association.
- Hughes: Well, how were committees appointed?
- Gumbiner: They had a cute little way of doing it. The chairman would appoint the nominating committee and the nominating committee would then nominate one slate, which would be elected. The incoming president would appoint the nominating committee again for the next year, and again that nominating committee would nominate one slate, and so on. The president would always support the chairman and members of the standing committees.
- Hughes: Was it important to GHAA to have Kaiser as a member?
- Gumbiner: Not in my view. In my view the trade association would have been better off without them.
- Hughes: Why?
- Gumbiner: Because they dominated the association and were a deterrent to getting active people from HMOs other than Kaiser to engage in the organization, because they had no say-so.
- Hughes: On the other hand, didn't GHAA need the largest HMO in the country?
- Gumbiner: No, not necessarily. It thought it needed the dues.
- Hughes: Why had you thought initially that it was important to be active in GHAA?
- Gumbiner: Well, it was the only game in town. I thought, and still do think, that the health care game is played in Washington, D.C.
- Hughes: GHAA had a strong presence there?

¹See the History of the Kaiser Permanente Medical Care Program Oral History Series, particularly the interviews with Morris Collen, Clifford Keene, and Ernest Saward.

Gumbiner: They had a very strong presence and a big organization. Kaiser always had a strong presence and always had two or three full-time lobbyists there.

FHP's Washington, D.C., Lobbyists

Gumbiner: We have a two-person legislative office in Washington, D.C. Kaiser and, I think, Health Insurance Plan of New York [HIP] each have one person in Washington, D.C. These are the only offices any HMO has there to my knowledge.

Hughes: To this day?

Gumbiner: Yes. I think some of the insurance companies, like Cigna, have one person to represent the health plan.

Hughes: How do you explain that?

Gumbiner: Ignorance. These people are so busy putting these HMOs together and think the trade association [GHAA] lobbies for them, but it doesn't. They're just not cognizant of the fact that it's important, that the legislature will change the way they operate or maybe put them out of business.

Hughes: Well, you opened a Washington, D.C., office in 1977.¹

Gumbiner: That was a reaction to the problem we had with Senator Nunn's committee. If we would have had an office there at that time we would have been aware, hopefully, of what was going on.

Hughes: As it was, it came as a shock.

Gumbiner: That's right. It came as a complete sandbagging.

Hughes: Has the office forewarned FHP?

Gumbiner: Well, it's been useful to us in dealing with the bureaucrats in Washington, D.C., as well as a legislative post and an opportunity to present our views.

Hughes: You mean getting known and getting access to the people you need access to?

¹FHP News, Summer 1977.

Gumbiner: No. You know there are three houses of government. There's the executive branch; there is the legislative branch; and then there is the bureaucracy. Of course, there should be a fourth, which is the lobbyists. Whoever is president, or whoever is in Congress, it doesn't make any difference because the bureaucracy stays the same. Even if there is a political appointee as head of a department, he can't get a damn thing done unless the people under him want to do it. They say, "Yes sir," and they don't do anything.

Hughes: What sort of people did you have in your Washington, D.C., office?

Gumbiner: Oh, we had people that had been in the business of legislative advocacy for years. One of our people, Janet Newport, worked in the legislative advocacy office for the independent gas station operators, I think, and another person had a master's degree in political science and had worked in some legislator's office. He had been around the Hill and knew what the political process is.

Hughes: They were effective?

Gumbiner: Reasonably effective.

The Medicare Demonstration Contract, 1983

Hughes: Let's get back to Medicare. Tell me about the demonstration program.

Gumbiner: I was leading up to that. As I mentioned, one of the people who was on my bylaws committee was a fellow named John O'Connell. John started one of the first Medicare pilot projects in Massachusetts for another plan there. I got to know John in these many, many meetings. Sometimes you have so many meetings with people you get to know them better than you know your family because you spend more time with them.

Anyway, I chatted with John and said, "We'd like to start a Medicare program on the West Coast and there's no sense in you freezing to death in Boston every winter." So I recruited him to come out to the West Coast to set up our program, which he did. I found out about the Medicare program through John O'Connell. It was my original idea that we should have separate centers for Medicare because these people take a different type of care. They can't hear as well, they use four times the

pharmacy, they move more slowly, signs have to be bigger, and so forth.

Hughes: You said yesterday that Central Medical Center in downtown Long Beach didn't work out when you combined the Medi-Cal people and the more affluent people.

Gumbiner: I never said that.

Hughes: What did you say?

Gumbiner: I said it did work out.

Hughes: I'm sorry; I misheard you.

Gumbiner: Well, people said it wouldn't work out, but it did work out. However, I can tell you that when you try to combine older people with the other people, it does not work out. It does not work out.

The Hippodrome Center

Hughes: Where did you establish these centers?

Gumbiner: I had purchased an old broken-down skating rink years before that had about 20,000 square feet in it.

Hughes: You bought it with a purpose in mind?

Gumbiner: No, it was just inexpensive. It was a dollar a square foot and I'll purchase anything for a dollar a square foot. [laughter] So, I purchased that and it was lying around in an old tumble-down parking lot. When we got the Medicare contract they told us we had to have a place to treat these people within ninety days. We rehabed the skating rink within ninety days, a herculean task; seven days a week, twenty-four hours a day.

Hughes: You had to gut the inside?

Gumbiner: Yes. We used the hardwood floor, however. I designed the floor plan myself and got a designer to put the old art deco front back on it. You can see it down on Fifth and Alamitos streets.

Hughes: I've seen pictures; it looks very attractive.

Gumbiner: It is a medical center with x-ray and lab, doctors' offices, physical therapy, mental health counseling, and so forth.

Structuring the Medicare Program

Hughes: Did you have to hire new staff in ninety days or did you transfer people?

Gumbiner: Of course, we hired new staff and transferred people, all of the above. But it takes you a while to enroll people.

There were about six pilot projects preceding our risk contracts. I visited them all because some of them failed and some of them succeeded. I figured out that there were three or four things that made them succeed.

One was you have to get a lot of people in in a short period of time to spread the risk. If you just experiment with a small group, the first people you get in will be the sick people and that will kill your program. You've got to get a spread of sick people and well people, preferably more well people than sick people. In order to do that, you've got to have a multimedia advertising campaign that blitzes the area, which we did. We spent about \$1 million on our advertising campaign, which was a lot of money in those days. We brought in about 10,000 members in about six to eight weeks.

Secondly, you cannot charge members a premium. If you charge a premium, the only people who will buy the program will be those people who are sick. People who are not sick will not pay a monthly premium. Pretty simple. And you have to include prescription drugs. Otherwise people won't get their prescriptions filled and they'll end up in the hospital, which will increase your hospitalization and the cost.

Hughes: You figured this out by looking at why the other programs failed?

Gumbiner: Yes, and by figuring out things in my own head after I looked at the other programs. Everybody told me that we had to charge a premium. But we've been very successful and we don't charge a premium and we include prescription drugs.

So the situation is, the government gives us 95 percent of what they pay the fee-for-service sector for providing just the Medicare covered benefits. That's no prescription drugs, no

preventive care, no mental health, a deductible to go into the hospital (now it's about \$500), and 20 percent of the doctor's bill or a copayment. For that 95 percent, we removed the 20 percent; we removed the deductible; we added prescription drugs, mental health, preventive care; and we charged no premium. We still made money, the government saved 5 percent, and the people saved about 50 percent.

That made everybody really mad at us. [laughter] The government was mad at us because here they were losing money on 100 percent for half the benefits. They doctors were balance billing in addition to the fees allowed. We were not balance billing, which is a big part of it, while still providing all these benefits. They decided we must be doing something wrong. It couldn't just be that we were providing proper utilization.

Hughes: It was your competitors that were saying you must be doing something wrong?

Gumbiner: The competitors, other HMOs, the hospitals whose rice bowls we were breaking. We were using 1,200 hospital bed days per 1,000 people per year on Medicare and the rest of the community was using 2,400, or twice as many. We were using generic drugs on a formulary, so the proprietary pharmacy companies were mad at us, along with the pharmacists.

Hughes: Were generic drugs something that you evolved for Medicare?

Gumbiner: No, we always had that generic formulary.

Then the other doctors were mad at us because we had our own specialists in the program. I can't think of anybody who wasn't mad at us except the consumers, who were delighted with us.

Now, the government, HCFA, was schizophrenic about the program. They were like a person driving down the street with one foot on the gas and the other on the brake pedal. On the one hand they knew our program saved them a lot of money and provided better care, more of it, and better access. But on the other hand, they were criticized because they were asked why they couldn't make fee-for-service work like that.

When Congress passed the catastrophic bill [Catastrophic Health Care Act of 1988] a couple of years ago, we were already providing almost everything they had in that bill for no more money. They voted it in, raised taxes, then repealed the bill the following year, and Congress had egg on its face. They're still trying to figure it out, claiming that we must be doing

something wrong if we can provide all of the care for less money.

Hughes: None of the HMO contractors were coming close to what you were providing?

Gumbiner: Oh yes they do. There's one that copies us; PacifiCare copies us. Every time we do something, they do it. They have a few of our people over there that I trained.

Hughes: How do you feel about that?

Gumbiner: That's all right because they are strictly an independent practice association and, in my view, they're basically going to head into trouble.

Independent Practice Associations (IPAs)¹

Gumbiner: In the IPA you cannot guarantee capacity. Instead, when you go into an area, you're actually doing a joint venture with the existing doctors and hospitals. Those doctors and hospitals are not going to multiply and divide themselves like amoebas, right? Who's there is there, and they're not going to take the risk of expanding their office or bringing in new doctors for the HMO. So, all that leaves you is to go to other territories. With the staff model we can go in, we can recruit doctors, we can build buildings, and we can increase capacity on a planned agenda. For example, if there are not enough orthopedists in the community, we bring in orthopedists. If there are not enough doctors in the south of Phoenix, we put in a center and we put the doctors there. We devised a combined [staff model] HMO and IPA when we went into Phoenix, Tucson, and Albuquerque.

Hughes: But you'd been involved with IPAs before then.

Gumbiner: Yes, I knew all about them. I knew they were unstable.

Hughes: Why did you use them then?

Gumbiner: In Guam, over fifteen years ago, I put an IPA in because we didn't want the staff model to take over the entire island since

¹This section incorporates a later discussion of IPAs.

then we'd be accused of monopolizing their health care. So in Guam we put in the IPA to support the staff model.

We did it backwards in Phoenix; we put the IPA in first. The IPA is a very quick entry into a community because you have no investment. But one problem is you can't control the doctors. In other words, you can't go to every IPA doctor's office and say, "I want you to clean this mess up." You can't control the quality that well either; all you can do is kick somebody out and set standards. And you can't make the doctors keep their offices open any particular time. They all want to close their office on Wednesday afternoon and play golf. That's it; you don't have any service.

Hughes: And yet, you're using IPAs more and more.

Gumbiner: Yes, because they're easier to manage, they're a faster entry. However, in my personal view, they will eventually prove less stable. Let's face it, the average doctor joins managed care not because he's enthusiastically and philosophically for prepayment. He or she does it because they're frightened of losing their patients to doctors that are associated with these HMOs.

The quickest way to start an IPA, as I mentioned before, is to put a staff model into the town. Then the rest of the doctors really run around and form an IPA. You take the staff model away and the IPA disappears.

Hughes: Well, does FHP have a tighter hold over IPAs than other associations?

Gumbiner: Oh yes. Now why is that?

Hughes: Because you are prepared to fire the doctors?

Gumbiner: No, that's not why.

Hughes: Why?

Gumbiner: Because if they don't cooperate we have the capacity to put a staff model into the IPA to help maintain the capacity of the HMO, and the other HMOs can't do that. At least they've not demonstrated their ability to do it.

The IPA HMO is an organization that administrates and markets the services of hospitals and doctors. Actually, they market and collect the money, plus they make sure the doctors and hospitals are paid from a certain formula. However, they

cannot guarantee access because the doctors run their own offices and the hospitals run their own hospitals. And they have a bit of a time guaranteeing quality also. They can't make anybody do anything--all they can do is kick doctors out of the IPA if they're really bad physicians. So an IPA is just one step up from an insurance system since it's not really an integrated HMO in that you cannot control availability or quality.

Hughes: Now was that concept originated at the time of the HMO Act?

Gumbiner: No, it was prior to that. In the late sixties, when the first prepayment program for Medi-Cal in California was conceived, there was a group of doctors in a medical association--I think it was San Joaquin Medical--that had a type of IPA. They provided their services on a prepayment basis for one flat monthly fee. The group distributed the fees among all the doctors according to some formula of billing. The total fee per month was a percentage of the premium, that is, a percentage of the money available. The doctors divided it up on a sliding scale among themselves. We put something like that together in Guam in 1973.

In any event, in 1992 the majority of the HMOs in the country are IPAs. In fact, FHP delivers about 50 percent of its care through our IPA division and about 50 percent through our staff model division. The thing about the IPA is that it's so easy to start up. It takes no capital and all you need is an office, a typewriter, a computer, and someone to sell the program. That is, after you initially get a HCFA contract, because fundamentally you're doing a joint venture with the doctors and hospitals. They supply the facilities, the manpower, and everything else, and all you do is sell the product for them.

Hughes: Do those advantages outweigh the disadvantages of the loss of control over the doctors?

Gumbiner: Up until about a year or so ago we were the only staff model that was public and where investors could buy stock. However, I think there are a couple more now. In answering your question, advantages to whom?

Hughes: To you, to FHP.

Gumbiner: Sort of a naive question because we've debated that for hours. All I can give you is my opinion, which is not shared by everyone. The IPA is easier and less costly to put together; you can make more money at it because you pass on the losses--

lower rates or inadequate increases--to the doctors and hospitals. If the doctors only get a 5 percent increase in their portion of the premium, and their costs go up 10 percent, they lose 5 percent. The average doctor is not organized well enough to know what's happening, so he just works a little harder and takes a little less home. Some of the hospitals may recognize what is happening but can't do anything about it because they are afraid the HMO will move or they can't afford to alienate their doctor staff.

On the other hand, IPAs, as I've said, are much less stable. A major IPA in Boulder, Colorado, was one of the shining examples a few years ago. One Friday night the doctors all got together, stampeded and quit, and the IPA was gone by Monday. They failed because, what were they? They were just a marketing and administrative organization with no doctors or hospitals to save them. We developed a combined program, or mixed model, in Arizona where we first had an IPA, and then supplemented it with the staff model, thus precluding a walkout.

The other problem with IPAs is that you cannot guarantee capacity because what you have are the doctors in that community. If you don't have enough general practitioners, you just don't have enough general practitioners, and if you don't have enough internists in a particular part of the city, you don't have enough internists. If you're dependent on just the doctors and hospitals that are there, you're at the mercy of a group of people who you are doing a joint venture with but who are not particularly tuned in to what you're trying to do. They would prefer to be back in the good old days with fee-for-service if they could. However, they can't so they may be resentful or, if you only have one or two hospitals, they may hold you up by not conferring or by higher charges.

By merging small staff model units within an IPA, we're able to fill in where the IPA doesn't have capacity, and we're also able to stabilize it. If everybody wants to quit at once, we're fine because we can just expand the staff model portion. The IPA gives us entry a little faster, rather than waiting to build facilities and recruit physicians. It also has more flexibility and variety through the use of IPA doctors and hospitals.

The staff model, on the other hand, has several disadvantages from a cost and organizational standpoint. You have to have facilities, you've got to borrow money to build them, you have to recruit physicians, you have to train them once they are hired, and you have to be responsible for their schedules.

Hughes: But if you have definite ideas of how health care should be delivered, which you do, I would think that it would be overwhelmingly preferable to have a staff model than an IPA.

Gumbiner: Well, then you get into the illusory part that we discussed previously. As an example, everybody would like to have their own personal physician living next door to them, one who is on duty 365 days a year, and one that does not send bills. Right?

Hughes: Where is he? [laughter]

Gumbiner: That's right. Plus, he is kindly and keeps up on all the new things in medicine, and can do everything for you--can send you to the right specialist at the right time, and can also control the situation, right? Well, he doesn't exist.

The staff model is a most effective and efficient system. For instance, you say to somebody, "Would you rather have an IPA model where you can use the local doctors around your area, or would you rather have to drive fifteen minutes to the staff model unit?" They might tell you, "We'd rather use the local doctors and have an IPA." Never mind the fact that there aren't any local doctors around, or they can't find them, or the ones that are there are too busy, or you name it. Thus, this illustration leaves a great gap between reality and perception.

The staff models are also less flexible. Say that your plan calls for enrolling another 50,000 people within the next two years, so you must have fifty more doctors. And say you don't enroll 50,000 more people. Now you've got twenty-five too many doctors and maybe you've got fifty square feet of facilities that you can't use. The key is to accurately phase the program and coordinate it with marketing, staffing, and facilities development.

Hughes: Has that indeed been a problem at FHP?

Gumbiner: Not while I was in charge since my policy was to market first and then develop the facilities and then the staff. If you're an IPA all you have to do is calculate what you think the rates are going to be and what inflation is going to be, and you try to develop your benefits and rates to fit that. The IPA takes care of the staffing and facilities development.

With the staff model you've got to go one step further, that is, you've got to supply the facilities. In an IPA it's easier to flex down if you don't get the rates or the enrollment. The doctors that are enrolled in the IPA are simply going to have less of their practice in the IPA sector. They're

either going to get fewer patients or more patients which, of course, is a big problem. Say that you enroll more than you thought you were going to and the doctors can't handle it. They're not going to hire more doctors. So that's the good and the bad of IPAs.

In a recession the IPA is, obviously, the easier program to run, financially and management-wise, because you don't have to flex down. The doctors just don't receive as many patients or as much income. In an expansionary period, the IPA is a poor model because it doesn't have the capacity to add volume (it can only take a certain number of people). Flexing down a staff model is like trying to steer a big ocean liner; the bigger it is the more difficult it is. My philosophy is to have a combined model that gives you the stability of the staff model and the flexibility of the IPA.

Hughes: And that's what you more and more are using?

Gumbiner: Yes, but on the other hand, that brings other problems, mostly hospital problems like we've had in Utah where we didn't have a hospital. We had a very good contract with a hospital there for ten years--I know that Kaiser had this problem too--and all of a sudden they get a new hospital administrator (some guy that goes by the numbers) and he says, "Hmm, if we charge the HMO a lot more money, we'll make a lot more money." Then they turn around and say, "We're raising your rate 25 percent." Never mind that the HMO is on a set income that is overburdened. So the HMO decides to find another hospital. Now that hospital has empty floors and, of course, they fire the hospital manager. However, that didn't help them, it didn't help us, plus we have the problem of reorienting a new hospital administrator and a new set of hospital-based doctors.

More on FHP's Medicare Program

Hughes: Did you have your staff at FHP fully behind you when you moved heavily into Medicare, or was that a battle on its own?

Gumbiner: I don't recall a problem in that instance. I think they were pretty convinced to trust my vision and research because by that time I had pretty firm control over the organization. There wasn't much of a problem--a few comments by nervous Nellies.

Hughes: You mean firm control compared to what you had with Plaza Medical Group?

Gumbiner: At Plaza Medical Group, a partnership, I had very little control.

Hughes: What are you comparing it to?

Gumbiner: As you become more successful, you have more people who are willing to run with you. So I don't recall that selling Medicare to the FHP staff was a big problem. I don't recall anybody thinking that we were taking a big risk or even questioning it.

Hughes: Well, I have the impression that Medicare was seen as risk by most HMOs.

Gumbiner: By many in the HMO industry, not by me.

Hughes: Oh, I know that.

Gumbiner: I guess maybe there were some people who were afraid of it. However, they were more afraid of me than they were of Medicare so they kept their mouths shut.

Hughes: That I can really believe.

I read that in 1988 Medicare accounted for 56 percent of FHP's operating income. In fact, you were the nation's fourth largest provider of care to Medicare beneficiaries.¹

Gumbiner: I think it's second largest now, right behind Humana.

Hughes: Do you worry about a change in federal policy that might eliminate the program entirely?

Gumbiner: I never worry about that.

Hughes: Do other people worry?

Gumbiner: Maybe.

Hughes: Complete elimination of the Medicare program is a possibility, is it not?

Gumbiner: That's an impossibility.

Hughes: Why?

¹Modern Healthcare, May 20, 1988, pp. 39-40.

Gumbiner: Why? Because everybody gets old or they die. You've got two choices, you die or you get old, right? Therefore, there will be more older people in our future, not less--and most of them vote.

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Gumbiner: It is a mistake to think of older people as poor, old, and sick. Our last two presidents are working aged Medicare eligibles. The wealthy and powerful get old or they get dead, right? And they're more likely to get old than dead because they're wealthy and powerful; they have better health care.

A great number of people in the over sixty-five age group have at least two pensions. They've got Social Security and they've got their pension from where they worked. Their house is paid for and they have more disposable income. So, if your clientele (i.e., the Medicare recipients) consists of some wealthy and powerful people who vote, Medicare is not going to go away.

Now Medi-Cal, on the other hand, is different. Its constituency is the poor. The poor do not have power, they do not have friends in high places, and they're the ones that always get screwed.

I see Governor Wilson reducing money to the welfare again. You always want to go out and screw the poor; they're used to it. But when you try it on the wealthy and powerful, they cause trouble. They call up their congressman, their senator (whom they've supported), and they complain. Therefore, Medicare will never go away.

Hughes: You said in 1987: "I think the new growth [of HMOs] will come from further expansion into the Medicare market, which is about 50 percent of the dollars spent for medical care in this country. I'd say that if an HMO is not in the Medicare market, they're not really going to be in the medical market."¹

Gumbiner: That's true. The Medicare people use approximately four times the health care that people under sixty-five use, on average. They constitute about 35 million people out of about 300 million people so that makes them about 11 to 12 percent of the total population. So if you take four times 12 percent (four times the health care, which means four times the expenditure), that equals 48 percent. That's pretty simple, right?

¹CEO Interviews, April 20, 1987.

Hughes: Right. [laughter]

Gumbiner: And the numbers are growing. Not only that, they're using even more of all these new, high-tech things that have been foisted on us by the pharmaceutical companies and the companies that make procedure devices. A bigger and bigger proportion of the health care dollar will go to folks that are over sixty-five.

Then if Congress goes along with Rostenkowski's bill and drops Medicare to fifty-five, then that just adds a whole bunch more people. Obviously, people from age fifty-five to sixty-five use a lot more care than people from thirty-five to forty-five. It's just inevitable.

Hughes: Is FHP's concentration on care of the aged strictly a money thing?

Gumbiner: It's not a money thing; it's a logical thing. That's where the care is going to have to be given in the future and that is where the need is today. Unfortunately, there are very few gerontologists in the country because doctors don't like to take care of old people. If the doctor is old, he identifies with them and he doesn't like that. If he's young, he can't understand them and he doesn't like that either. So proportionately there are very few gerontologists. Besides, everybody looks at themselves as if they were fifteen years younger and does not want to identify with older people.

Hughes: That's true.

Gumbiner: That's true; it's a fact. [laughter]

I always thought that doctors should be something other than techno-scientists; they should have a better and broader education. I used to have doctors' luncheons once a week and at one meeting I would have a lecture on a medical subject and at another one I would have a lecture on a non-medical subject-- anthropology, history, you name it. Of course I had to drag the doctors kicking and screaming to these non-medical affairs.

Hughes: It was obligatory?

Gumbiner: It wasn't obligatory; it was only if you wanted to continue working at FHP. [laughter]

Art in the Medical Centers

Gumbiner: Then, for many reasons, I got the idea that medical centers should have artwork throughout: it was a morale boost for the personnel, it was a good marketing tool, and it was therapeutic as a mood elevator for the patients. Maybe nineteen years ago I found this lady, Elaine Marienthal, who was an artist and a decorator. She works for us full time now. Her job is to put artwork throughout the medical centers. We use mostly limited-edition prints, etchings, lithographs, serigraphs--art that is quality but reasonably priced so that patients don't get the idea that we are spending their medical dollars on decor.

The whole thing about artwork is that the piece itself should be interesting and in a proper frame. It's important where and how it's hung, plus the relationship to decor, planting and furnishings. You may have gone to our hospital.

Hughes: I did.

Gumbiner: You'll notice there's artwork and planting all over the place. It's not the usual garbage seen in most hospitals, such as the chairman's portrait and a few photo reproductions.

I decided that we would have an art gallery in our center in the Hippodrome because there should be something more for waiting patients to do besides read magazines. So I allocated about 1,700 square feet for an art gallery. Of course, the doctors all complained that they wanted to put a lab in there, but I fought them off valiantly and hired a curator. I went through a couple of curators until I found the present one.

It's proven to be a really excellent public relations vehicle, in addition to adding something to the community. Everybody is very proud of it.

Hughes: Do you select the art yourself?

Gumbiner: No, why would I select the art myself? I have experts in the field to select the art. The art gallery has about three or four shows a year. Right now we have a show of WPA art. Do you know what WPA is?

Hughes: Works Progress Administration.

Gumbiner: You remember that?

Hughes: Thinly. [laughter]

Gumbiner: We dug up all the artwork that was done by the WPA in and around Long Beach and then published a booklet. We did a show on Micronesian art; we've done on the elders of the tribe; we had a great show of the artists among our senior group; we did one on lighting art; and we did a holographic art exhibit. We're very fortunate that we were able to develop a gallery that is not dependent on the political input of some civic board of directors like a municipal gallery, and also not dependent on the vicissitudes of the buying public, if you have a retail gallery. We are actually a corporate exhibit gallery. It costs us \$200,000 a year, but it's worth many times that much in public relations. It's the FHP Art Gallery. The Long Beach annual art tour starts there and we invite everybody to the shows.

Hughes: When you go to the Amazon, will you be looking for art to go into the gallery?

Gumbiner: We're going to do a South American show and we want to find the artists that we can use for the show. I'm also collecting privately for another gallery. Okay, enough of the art gallery.

Recently there was one organization that is getting art in health care, which is sort of interesting. The industry is just getting around to what we've been doing for twenty years.

Hughes: With the idea that art is beneficial to health?

Gumbiner: Yes, people get better faster in surroundings that are pleasant. That's why I built the hospital with floor-to-ceiling glass windows, combined with balconies and planting on the outside; you bring the outside inside.

Hughes: Have you been criticized for spending money on inessentials?

Gumbiner: Always, always. But it turns out that when I was running the place it always did well, even spending on inessentials.

Hughes: It's questionable whether they're inessentials.

Gumbiner: That's right. I consider them essentials.

Choosing the Location of Medical Centers

Hughes: Why do you pick a certain location for a medical center? What sort of research has to be done before you make such a decision?

- Gumbiner: Ah, that's very complicated. You have to have the right demographics and you have to be able to project five and ten years down the road what's going to be happening there. Traffic flow access is also important.
- Hughes: What sort of information do you use?
- Gumbiner: This is standard marketing information. You can go to any business school and they can tell you that. It's no big secret.
- Hughes: It doesn't have to be modified for HMO purposes?
- Gumbiner: No, standard management stuff--101A.
- Hughes: Why Fountain Valley?
- Gumbiner: You've got people in depth, with the demographics, the age, the income, and so forth, that are the backbone of our population. Plus it's got ready access to the freeway. I put all our centers on the freeway accesses so you could easily get to them.
- Hughes: That's true without exception?
- Gumbiner: I don't know what's happened the last few years because I haven't been doing it myself. When I was running it, every single one of our centers was not more than a block or two off the freeway, which is a critical element.
- Hughes: Well, access to a medical center was one of the criteria for success I saw in one of your position papers.
- Gumbiner: Access can be access in a macrosystem and access in a microsystem. Access in a macro sense is general access to the public. Access in the micro sense is, are the office hours appropriate? Are the proper staff there? Is it easy to get adequate parking? And so forth.
- Hughes: Are the extended hours that FHP keeps unusual?
- Gumbiner: Not for staff model HMOs. They have either an acute illness clinic, or an emergency room, or another system. I've always felt that medical care had to be available seven days a week, morning, afternoon, and evening. It seems odd to me that you'd expect people to take off work in the middle of the day just because it was more convenient for the medical staff.

Organizational Development

Gumbiner: I want to talk a little bit about the problems of developing from a smaller organization to a larger organization. One of the things I've been a student of is organizational development. Organizational development is a product of strategic planning. You have to be able to develop an organization in advance as it goes through its different phases of growth. You have to anticipate what you're going to need in staffing and organization.

In other words, if you have a group of people that, in their abilities and numbers, are able to manage an organization of a certain size, and you think you're going to be an organization of double that size in two or three years, then you have to have double the management today. Otherwise, you're not going to get there because the people you have today to manage the organization the size it is today are able to manage that size organization without the discretionary time to plan ahead.

There are a certain few people who, with superhuman effort or at least very good prioritization or appropriation of their time, are able to do many things at once. But mostly you staff for the ordinary, usual person, but then that is who we have in life, the usual person. We have a few very superior people in their contribution to society, but they are hyperactive. Then you have some people who are just layabouts and never do anything, and then in between you have the average person. So you staff for the average person and therefore you need to staff for the company or organization you plan to be in the future. And then you have to pay attention to organizational development.

In the beginning I was just by myself, with one or two people helping me. Then I made the jump and developed a staff of four or five people to do all the things I was doing. Then I had a number-two person and myself. Then I moved up to planned development. I'd say about ten years ago I started it; I planned to have FHP go through a metamorphosis.

First I developed a matrix management setup. I had all the books pulled by the University of California Graduate School of Management on different types of management approaches for the complex organization.

Then I created an office of the president. I put my three top contenders for president of the company in the office of the president and I moved up to chairman of the board. In other

words, each one of these three people acted exactly like the president. I have a write-up on management development through the office of the president and also a write-up on the matrix system of management.

I had it all worked out in time phases. I developed the office of the president and from that it was a natural progression to the executive management committee, which would have no chairman. In the next phase, one of the three contenders would become president of the company. The executive management committee would act as the chief operating entity of the organization, and it would change personnel from time to time as we developed other people.

Hughes: When did you institute the office of the president?

Gumbiner: Oh, I did that about five years ago.

Hughes: This was anticipating your own retirement?

Gumbiner: Right. I did what you call "staged retirement." I was ready to get out about six or seven years ago, but the board of directors convinced me to stay on for a six-year contract where at the end of the first two-year period I could quit. They worked it out so that every year I'd get a 10 percent increase, or 1 percent of the net increase from the previous year. Then every two years, if I'd stick around, they'd give me another 25 percent increase. They sort of lured me into hanging around for six years.

I had to plan how to retire at any two-year interval during that six-year period. I developed this whole management strategy for doing that. Then I finally created the office of the CEO. Then I moved out of that, leaving one CEO and president.

An HMO is in the service business since it provides services for people, much like a restaurant or a hotel. But at the same time, it's in the finance business, something like an insurance company or a bank, because you have to try to project what the money rates and inflation are going to be like a year or two years hence. You deal with a lot of knowledge workers in the HMO. A large portion of people who work for the HMO have advanced degrees of one type or another--M.D., D.D.S., you name it. So I developed a whole series of training programs.

Providing Accessible Health Care

[Interview 4: February 18, 1992] ##

Gumbiner: The whole problem with health care in the United States is that for years people thought you could disassociate medical services from the management or financing of health care services. The reality is, you cannot separate the two.

I just got back from South America where I talked to the management of health care systems in Colombia, Venezuela, and Ecuador. It occurred to me while I was there that the same thing is happening in the United States that has happened there. Very typical of all three systems is the fact that they all had a public health system that allegedly took care of the poor, they all had a minister of public health to direct the program, and they all had a social security system paid for by the employer/employee that supposedly took care of the working person. The truth is, however, these systems really did not work. They didn't have the proper equipment in their hospitals, they didn't have availability or access of providers, and thus the people didn't get care. For instance, in Bogota there are several big clinics and ten HMOs where, supposedly, everybody is taken care of either by social security or the minister of health.

I thought to myself, gee, it isn't much different than Medicaid or Medi-Cal in the United States--a system that's being paid for but one in which none of the poor people can get care because they don't have transportation to get care and the doctors don't practice or live in the areas where the needy are. Even if the poor do find a doctor, most of the doctors don't want to treat them, with the exception of the highly paid specialists.

We have a Medicaid system in this country but it doesn't work because the care is not available in the format or in the geographic location that the people can use it. It really isn't very different than those in developing countries in South America, which also have it on paper but can't make it work. When you get right down to it, what good does it do to have excellence in medical care if nobody can access the care, either because of the financial barriers, or it's not geographically available, or they don't know about it?

In this country, if you woke up one day with a brain tumor and you wanted to find somebody who was the best in the country to take care of this condition, you would have a heck of a time

locating that person in the next six months or before you expired. Unless we develop a system to make the care available and accessible geographically and financially, it's useless. It's like the old saying, "Is there any sound if there's no one to hear it?"

My philosophy of health care is to make it available in a format and place so that people can or will use it. It gets back to something that's simplistic enough: if you don't trust your doctor because of the way he presents himself, you're not going to do what he suggests. If he suggests some procedure, you say to yourself, "Wait a minute, I'm not going to do that because I don't think this person knows what he's talking about." The doctor may write you a prescription but you don't get it filled, and thus the encounter is useless. So, we are back to the training of medical personnel as part of health care access.

Hughes: The right kind of doctors, you mean?

Gumbiner: Training people from the right social, economic, and cultural background.

Hughes: Right in what sense?

Gumbiner: Say you had people that came from a very elitist background; they wouldn't have much empathy for people who weren't in their particular financial, social, or racial category. I don't like to digress, but with the price of medical school education going up to \$25,000 a year, plus living expenses, you're bound to end up with nothing but white, upper-middle- or upper-class doctors, with a smattering of people who were lucky enough to get a scholarship. One of my philosophies is, we've got to start getting people into medical schools who are from various and diverse backgrounds. You may have to pay them a living wage to go to medical school, but in return they would agree to work within the system.

Hughes: The patient population has different backgrounds. Which ones are you going to choose?

Gumbiner: I don't think so. I look around in our waiting rooms and I'm amazed that people look pretty much alike. They're a pretty good cross-section of the American middle class. Of course the thing about the United States that makes us unique in the world is to have probably the largest middle class of any industrialized nation. In many of the other nations you have a larger lower social-economic class, or you have a larger upper class. There is a tremendous misappropriation of wealth in most of South America--you have the very wealthy or the very poor.

Hughes: Nothing in between.

Gumbiner: That's right, just a very small middle class. I don't think Great Britain has the middle class that we have. They have a lot of what you call working class and then, of course, the upper class.

Hughes: But their medical schooling is less elitist than ours.

Gumbiner: I don't know about that. A lot of the people that get into medical schools go to private schools (what they call public schools) before they even get into the universities. The British are infamous for figuring out by your accent whether they will talk to you or not, because if you have the wrong accent some won't even talk to you.

My philosophy is that we should really try to produce the most care for the most people for a reasonable price, and make it accessible.

Hughes: Now how do you go about making it accessible?

Gumbiner: The first thing you do is have a system. In other words, you may have to have all facilities available at one location, and you might have to have them open twelve hours a day, seven days a week. That's pretty simplistic. But the average solo fee-for-service doctor obviously can't be available twelve hours a day, seven days a week, so you have a system where the individual will select a group of doctors.

The Myth of the Personal Physician

Gumbiner: Now the patient prefers one doctor but that doctor obviously can't be there every day, 365 days a year. So there may be a secondary or tertiary doctor; the patient knows another doctor in that group or maybe a third doctor in the group. The key, of course, is that the patient's records are all in one place so that doctor number two or doctor number three has access to all their records, just like doctor number one has. If you go to an unsystemized private solo practitioner, the doctor doesn't even have your chart (he doesn't have any records) and he doesn't know anything about you. You may have to go to a doctor-in-the-box or an emergency room, or whatever is available. That might work for 50 or 60 percent of the problems you present because they're acute, but there is certainly no rapport.

This is always an interesting bit of philosophy. People talk about the fact that everybody should have their own physician, and physicians should have rapport with the patients. But I have become convinced over the years that the majority of people don't have a doctor, they only think they have a doctor. They perhaps saw a doctor two or three years ago. But in an urban setting they have a lot of different doctors. They have an internist, a gynecologist, an orthopedist, a pediatrician, and a this and a that, but they really don't have a personal doctor as such. We've proven that over and over again. If we have to shift our health care coverage from one group of doctors to another, 70 to 80 percent of the consumers will stay with the plan and give up the doctors they had because they're not that attached to them. That makes sense because most consumers don't go to the doctor that often; only about 20 or 30 percent of the people go to the doctor relatively frequently.

Hughes: But isn't the problem a conceptual one, that many people think they should have a personal doctor, regardless of whether they do or not? So if you're trying to sell a plan where a person is not guaranteed a personal doctor, you are going to run into trouble.

Gumbiner: We don't sell that kind of plan; we sell the plan where we want you to select a personal doctor. The problem is, people won't select a personal doctor. There are three types of people. There is the person that selects a personal doctor and will only go to that doctor. It's like people that only go to one hair stylist--they will wait for a month until they get an appointment with the hair stylist they want. There is the person who usually goes to one doctor but if he or she is not available will go to another doctor as long as he's wearing a clean white coat and looks like a doctor. Then there is the person that doesn't care what doctor he goes to. He will go to the doc-in-the-box or to emergency. It could be a busy executive who has a little skin rash and wants to know what it is, a minor thing. It is also amazing that sophisticated executives, who very carefully look at every problem, would allow some doctor to tell them they need a procedure done and will hop right up on the table and want it done, without getting a second or third opinion. That's characteristic.

Hughes: Well, the perception is that doctor knows it all.

Gumbiner: They know that the architect doesn't know it all, the lawyer doesn't know it all, and they probably have ten lawyers working on one problem.

Hughes: Yes, but there's still that mythology about the doctor.

- Gumbiner: That's what I'm getting at; that's the philosophy that's so wrong.
- Hughes: I still think that there's the myth out there, certainly with the older generation, that to get good medical care you have to have a personal physician.
- Gumbiner: But you see, the personal physician, the general practitioner, is disappearing or has disappeared. Why would anybody want to stay in a field that's more difficult, less profitable, and less prestigious?
- Hughes: Oh, I'm not talking about the physician; I'm talking about the perception on the patient's part.
- Gumbiner: I know what the perception is, so it's an educational problem. Physician selection is an educational problem. In our California unit we've got sixty internists, most of whom act as primary care physicians for adults. We have a hell of a time getting people to select a physician. If you have sixty physicians of any kind, 20 percent of them will be very popular, 20 percent will be unpopular, and 60 percent will be popular in varying degrees, right? Out of the sixty internists, a certain group of them are booked up all the time and a patient can't get an appointment with them. There will be another group no one wants to see (we try to get rid of those and put them back in fee-for-service practice).
- Hughes: But the problem is, there's a difference between what the patient perceives he wants in a physician, and good medicine. I suspect that the American public chooses a physician the way they choose a president--image rather than substance.
- Gumbiner: Well, you'd have to define what good medicine is. That's another problem. If the doctor is interested in the quality of the procedure and not in the quality of life, he'll take out one of your organs. The operation will be a great success but you won't be very happy the rest of your life.
- Hughes: That's not good medicine by most people's definition.
- Gumbiner: Oh, some doctors think it's good medicine if the procedure is well done. Never mind the fact that the patient is not going to get along very well for the rest of his life. A doctor wants to do a prostatectomy on somebody and he says, "Oh, but it will cure your cancer." However, he doesn't tell you that you'll be incontinent and impotent the rest of your life. The patient doesn't like that very well. [laughter] The patient says, "Have you got another procedure, doctor?"

- Hughes: Have you had the problem of a physician who was not very adept at interpersonal relationships and yet was a good doctor?
- Gumbiner: Let me beg the question then. If he's not very good at interpersonal relationships--and the practice of medicine really is interpersonal relationships--then how can he be a good doctor?
- Hughes: Well, that's true, somewhat depending on the specialty. I guess personality isn't too important in an anesthesiologist.
- Gumbiner: Yes, or a pathologist. Even some of the surgeons, who are real cretins as far as talking to people, can be very skillful in the operating room.
- Hughes: How did you balance all that?
- Gumbiner: How did I balance it?
- Hughes: Well, you presumably were making decisions in the early days about who stayed and who left.

Selecting Physicians

- Gumbiner: In the early days we tried to find people who could establish rapport. It's easier to teach people to be careful in health care than it is to teach them rapport. Right now FHP has all kinds of systems. We have a training program for physicians where we teach them to interview patients. This is done through television playback, critiques, and all sort of things. If we get somebody that is very shy, or very angry at life, or whatever, we are not going to be able to help them.
- Hughes: Have you been pretty successful in screening out those people initially?
- Gumbiner: You can be reasonably successful, obviously, if you've got thirty or forty minutes to interview somebody. Say that somebody is interviewed by five or six doctors--the chief of their service, medical management, and so forth--each one fills out a critique form and then you compile the results. You're still not going to know, however, how the interviewee gets along in a new environment. A certain number of people are not going to pass the first test. In other words, in the interview they're not going to make it. The first thing that happens, of course, is their résumés are not very good--they jumped around

from place to place--so you don't want them. Or maybe their references are bad--they can't get along with anybody. And then maybe in their interview something comes to light. Given that they pass all this, when they get into your organization and in your particular environment, some of them may not turn out.

Hughes: Particularly in an HMO. In the early days, they probably didn't understand exactly what you meant by an HMO.

Gumbiner: It goes further than that. Some people come to California and then decide they don't like urban living in California.

I started off by saying that the practice of medicine cannot exist in isolation, unless maybe you're doing the ivory tower, academic type of medicine. But even then you still have other problems if you don't publish, or can't teach, or whatever it is. Health care can't exist in isolation. A lot of government people think that doctors know how to organize health care, deliver it, make it accessible and affordable, and that's a big mistake. That mistake is what I keep talking to a lot of the politicians about and they don't get it, they just don't get it.

Hughes: What don't they get? That doctors don't know business?

Gumbiner: I don't know what you're talking about when you say "business." They don't know how to manage anything.

You're like the academicians. They think over here is business and over there is something else. You are all in business, unless you don't like to get a paycheck. If you're working free, then you're not in business. So, you're in the business of collecting a paycheck.

The whole question is, all doctors market their services. What good is a doctor if he has no patients to see him? Doctors market their services by different means: they go to all the medical meetings, they serve on the hospital boards and committees, and they do good public works.

Hughes: Tell me how FHP was and is distinguished from other health maintenance organizations.

Gumbiner: That's a big mouthful. It would be easier to have told you that five or ten years ago.

Hughes: Well, start there.

Gumbiner: The 1973 HMO Act didn't really take effect until 1974 as it wasn't passed until December of 1973. If my recollection is correct, it was passed in one of the last sessions of Congress before the end of the calendar year. Before 1973 there were only organizations called group practice prepayment plans (GPPPs). As I mentioned, I was chairman of the membership committee of Group Health Association of America. We wouldn't let people who were not group practice prepayment in the organization because it was a trade association of group practice prepayment plans. When the act went through at the last moment, organized medicine woke up to what was happening and they put into the act something called the independent practice associations (IPAs), which was really more or less a loose association of physicians.

The HMO Act

Hughes: If you want to talk about the HMO Act, I think now might be a good time.

Gumbiner: Did you ever get my presentation to one of the congressional committees on the 1973 HMO Act?

Hughes: No, but I want to hear about that. It was the Subcommittee on Public Health and Environment of the U.S. House of Representatives.

Gumbiner: Yes. A lot of the ideas I had advocated in my presentation actually came out in the bill. I suggested that they mandate that employers have to offer an HMO, and that actually came out in Section 1310 of the HMO Act.

Hughes: Organized medicine didn't protest that stipulation?

Gumbiner: Organized medicine was caught sleeping at the switch. The bill went through right before Christmas. The American Medical Association got in on it by putting in the IPA clause so that organized medicine would have a chance to have these loose associations called IPAs. As I said, the IPA is a marketing and administrative system, and that's all it is, as it doesn't actually deliver the care. A staff model, or a group practice prepayment, actually delivers the care, builds, buys, or rents the facilities, buys the equipment, hires the doctors, and actually manages the system.

Hughes: How did you come to testify?

Gumbiner: I was invited by the subcommittee. I was always following the Washington scene because I knew that's where everything happens.

Hughes: How were you following it?

Gumbiner: As I mentioned before, I was lobbying for Medicare in 1965 and 1966 and I would go to Washington periodically to see my congressmen and senators. I heard about them taking testimony on this bill so I volunteered to testify and they put me on the program.

Hughes: What else did you say?

Gumbiner: I don't recall, 1973 is a long time ago.

FHP Becomes Hospital Based

Hughes: FHP became a hospital-based operation and the first hospital was built in 1986. What was the philosophy?

Gumbiner: The philosophy is very simple. At the time we built our first hospital, there were plenty of empty hospital beds all over Long Beach and Orange County. The question was, why would we want to build a hospital? The answer is: I probably spent two or three years looking at hospitals and trying to buy one, but the existing hospitals were either not up to our standards, were too small to begin with, or in the wrong place. The main drive in the average hospital is to lure physicians into the hospital so that they can send their patients in. The hospitals buy extra equipment that they don't need, which raises their cost, and they do all kinds of things that are not very practical or efficient businesswise. Thus, you're dealing with a dinosaur.

We haven't built many hospitals in the last ten years. Many hospitals built in the sixties and seventies were popped out with cookie cutters because some hospital corporation wanted to make a lot of money and get in first with not much care or concern as to how efficient or effective they were, either for the doctors or the patients. Or they were built just the way hospitals have always been built, that is, by some not-for-profit company or organization. The Sisters of Charity built the hospital they always built, and so forth.

The hospitals that we could put our FHP patients in charged too much because they were wasting about a third of their money

on things they didn't need--things that pampered doctors or competed with other hospitals, duplicating other hospitals' equipment and facilities, so they could get patients in their hospital rather than in another hospital. It came down to: we weren't going to pay what hospitals asked, they were in the wrong places, they were too big and impersonal, or they were too small and decrepit, ready for the bulldozer.

In addition, hospitals wouldn't let our doctors on staff because they were controlled by fee-for-service doctors, and their main objective was keep the prepaid doctors off the staff. Even if they got on staff, the hospital would keep them from doing surgery--it was the same old story. As a partner in one of the fee-for-service doctor groups, you could get surgical privileges pretty quickly. However, if it was an HMO doctor they'd make him do every procedure ten times over until they would finally grant him privileges, or until he went away. Of course that's nothing new. If he was not a partner with an established fee-for-service doctor, but merely a new doctor coming in, they'd do the same thing to him.

Hughes: What do you mean by a hospital-based operation?

Gumbiner: This means that the HMO controls its own hospital rather than using someone else's.

Building the Fountain Valley Hospital

Hughes: Why did this come to a head in 1980?

Gumbiner: Because we were big enough then. It's a simple formula; you have to have at least a hundred-bed hospital to be efficient, and you need at least 100,000 people to use a hundred-bed hospital if you use around 300 hospital bed days per 1,000 enrollees.

Hughes: Why did it take six years? Fountain Valley Hospital didn't open until 1986.

Gumbiner: First of all, we had to acquire the land and then we had to get the financing.

Hughes: Something I read indicated that in 1980 FHP converted to a hospital-based operation, and a \$27 million bond issue was passed to construct a hospital in Fountain Valley.

Gumbiner: That's when we probably got our bond issue started.

Hughes: So it took you six years to build the hospital? You must have had the land if you were talking about Fountain Valley.

Gumbiner: Yes, I don't know the exact date, but I can tell you that the usual cycle will take you five years to build a hospital. It actually takes you two years just to plan. If you were to build it within two years that would be pretty speedy. It takes you two years to design it and get through the state's architectural office. It may take a year or two to finance it, and then it takes two years to build it.

The first thing you do is make a plan. First of all you do a market study to find out where it should be, then you have to acquire the land, then you have to get the financing (trying to get a bond issue through the California Health Facilities Act). We spent a year before that, unsuccessfully, trying to get conventional financing.

Dealing with Jesse Unruh

Hughes: And how did you eventually achieve financing?

Gumbiner: We got a bond issue as a nonprofit organization through the State of California Health Facilities Act, where the state of California had agreed to guarantee several million dollars in bonds for hospital construction. The bond issue was actually sold to the public by the hospital corporation and the hospital paid it back from revenues. However, somebody had to guarantee the bonds. Therefore, the state of California set aside a certain amount of money to guarantee these bonds for the not-for-profit HMOs. The act was around for about two or three years with no takers, and the same day we came in with our proposal, Kaiser Permanente also came in with a proposal. Jesse Unruh was the chairman of that particular bond-issuing organization and he threw us both out. [laughter]

Hughes: On what grounds?

Gumbiner: I think on the grounds that we weren't contributing enough to his PAC [political action committee].

Hughes: That sounds like Jesse Unruh.

Gumbiner: That's right. Jesse Unruh had what they call an "underwriters' PAC" for Jesse Unruh. [laughter]

Hughes: It actually had that name?

Gumbiner: Yes. He actually figured out that to protect the people of the great state of California, he would decide which underwriters the state should use. It had nothing to do with how big they were or how well established; it depended upon his own set of criteria. All of these underwriters had formed an underwriters' PAC and Jesse couldn't get it through his head that we weren't a group of for-profit doctors that he was trying to get to contribute to his PAC; we were only trying to build a hospital. It took me about a year, going in three or four times to meet with Unruh and the committee he chaired and having them kick us out on some trumped-up charge or another. Finally I convinced his assistant treasurer that we were definitely a not-for-profit organization and couldn't legally contribute to his PAC, that we didn't have any money personally, plus we wouldn't contribute anyway. Then the whole thing turned around--we walked in and they said, "Well, we think this is a fine program," and approved the bond issue, patted us on the back, and wished us good luck.

Hughes: How did you find the land?

Gumbiner: There was a lot of discussion about where to put the hospital. I had purchased the land (about ten acres) years before that in Fountain Valley.

Hughes: With the idea of putting a hospital there?

Gumbiner: Eventually, but then we merely wanted to expand the medical center. Subsequently we purchased some more land behind the medical center from a developer, which gave us a site large enough for the hospital. We tried to buy a couple of other hospitals for a larger potential site, but it turned out that they were either too expensive or, as soon as they found out our organization (with so many doctors involved) wanted to buy it, they would immediately increase the asking price. That is when we decided on Fountain Valley where we already had a site.

I had purchased this site many years before through a limited partnership of which I was the general partner. Several of the doctors and managers had put up money and had been paying off the loan on this land for years. I put up half of the down payment and they put up the other half, put in dollar for dollar, and took nothing for the development and risk as the general partner. That hospital took a long time.

Planning the Hospital

Hughes: How directly were you involved with the planning?

Gumbiner: I did all of the planning. I did the planning for the people flow and the paper flow. I went around and looked at probably half a dozen fee for service hospitals and half a dozen prepaid hospitals, including all the prepaid hospitals I could find, which were only a few. This included Group Health Cooperative in Puget Sound and the Kaiser hospital in northern California, Oregon, and Hawaii.

In all of the prepaid hospitals I looked at, I found they had one thing in common. The prepaid hospitals seemed to be constructed for the comfort and convenience of the patient or consumer. The fee-for-service hospitals were constructed for the comfort and convenience of the doctors and nurses. Beds would face the corridor in the fee-for-service hospital so the doctors and nurses could more easily see the patient, the windows were small, and the decor was negligible. In the prepaid hospitals, Kaiser used to build hospitals with balconies and rooms with floor-to-ceiling glass. The public hospital corporations catered to the needs of the doctors because they made their money by getting doctors to put their patients in their hospitals.

In any event, I conceived the idea that the hospital should be built for the convenience of the patient and I was involved in all developmental details. For instance, we didn't use plastic guard rails but used oak instead. We trimmed the mirrors in oak, and we put an oak panel over the gas outlets that could be flipped down when in use so it didn't look like a hospital.

One of the biggest discussions we had was whether we were going to use carpeting or hardwood flooring. The nursing staff wanted hardwood floors throughout for their convenience and the marketing people wanted carpeting throughout for their sales effort. Finally I said, "I'm tired of listening to all of you, so what we'll do is put hardwood floors in the corridors and carpeting in the rooms."

Hughes: Was that a good idea?

Gumbiner: Yes, it worked out fine. People worried about the noisy carts and people walking in the halls. I said, "Did you ever hear of rubber wheels and rubber soles on shoes?" Other people said,

"People will spill on the carpeting." I asked why they thought that--no one answered.

Another big problem was the television. I said I didn't want big ugly television sets on the walls. Instead we put in little personal television sets on an arm that could be swung around. I can tell you that the hospital management is totally unconscious that they're in the service field, or of imagery, or of the healing environment.

Hughes: I saw a reference to a standardized premanufactured modular medical center.¹

Gumbiner: I built several of those years ago. I had a well-known architect, Barry Burkus, design the modules to fit into the community. The idea was that if you could get more usable square feet out of a premanufactured modular center, you wouldn't have to design the same thing over again. Besides, all the errors could be worked out on the prototype and you wouldn't have to make the same mistake over again.

But back to the hospital, there were certain basic concepts. The patients and the staff would not use the same elevator. Visitors don't want to see some poor guy going to surgery half dressed.

There would be a stairway next to each elevator so that if a staff person wanted to walk up the next floor, he didn't have to wait for the elevator. I put up a big sign that said, "Walk for health," and decorated the stairways with artwork and carpet to get them to use the stairways.

Another idea was the small waiting rooms on each floor of the hospital with a little consulting room.

Then we went through a debate: should we use a racetrack or a floor plan? We developed a system using a cross where the patient wouldn't be very far away from the nurse.

Then we developed a system where every other room would be a single room and every other room would be a double room, with the idea that you wouldn't have that many patients in the beginning so everybody could have a single room. Then if we needed more space we could put two beds in the double rooms. We filled up the hospital pretty quickly and used up all the double

¹FHP News, October/December 1972.

and single rooms. That's the advantage of the staff model managed care hospital--it's full when it opens.

The other idea was that the cafeteria should be attractive, with salad bars and deli bars, with attractive presentation. This was a real problem to get implemented, I tell you.

Hughes: Why?

Gumbiner: Because hospital administrators' brains don't work that way. Cafeterias are stuck in the basement, they throw slop on the people's plates because they get away with it (because sick people need special diets--bad). As an example, I said, "Well, I'd like to have a low-calorie special salmon salad plate, or something like that, that the staff can get for \$2.50." When I finally got them to do that, what did they do, they placed the salads at the end of the line, after the staff had been through the entire line and their trays were full. So, I raised hell about that and told them to put it at the beginning of the line. Eventually they did put it at the beginning but buried it so you couldn't find it. I then said, "Put a sign on it."

Ten years ago I decided there would be no smoking in any of our buildings, but people told me I couldn't do that. I told them fine, we'll do it anyhow. Now we have no-smoking buildings.

Hughes: Did the staff honor that rule?

Gumbiner: I built a little gazebo outside and had a sign on it--"Smokers Only"--for everybody who wanted to smoke themselves to death. Everybody had to go to the gazebo to smoke, even in the rain.

This is really funny. I had two big vending machines in the hospital for times when the cafeteria was closed. I had a sign put on one of them that said, "Junk Food" and I let them put all the junk food in there it would hold. On the other machine I put a sign up that said, "Health Food" which was where I put the apples and the health food. People kept tearing the signs off the junk food case--the fat ladies would tear off the junk food signs so they could eat the junk food and not feel bad about it. [laughter]

Another idea for hospital design was that you could go to the cafeteria without going through the rest of the hospital. You notice in our hospital that you go right through the waiting room to the adjacent cafeteria. The visitors' elevator faces the reception area. The two other elevators for staff (two for staff since visitors can wait but staff cannot) face the

interior corridor. Visitors and staff don't use the same elevator. I thought of a lot of things like that.

The big controversy was whether to have the OB [obstetrics] delivery floor up on the OB floor next to the surgery. I said we were going to have it next to the surgery because you might have surgery overflow and could use the OB, or you might need surgery if you're an OB patient--it was double usage.

Anyway, I was involved in planning the hospital down to the last detail, which is just the way my personality works--get down to the last detail and make sure it's right (if it was a long-term-effect decision).

Hughes: How did the hospital work?

Gumbiner: It was terrific.

Hughes: No problems at all?

Gumbiner: No, other than the fact that we had to reeducate all of our hospital administrators.

Hughes: About what?

Gumbiner: Doing things right and that they were in the service industry. I used to give them the lecture that they were in the service industry, not the hospital industry, and that medical care is a service-oriented business. One nurse wrote me a letter and said she was quitting because she didn't want to work for a hotel. I told her good, that I hoped she went to one of our competitors. Orienting the hospital administrators to the fact that we are in the service industry is pretty difficult.

Hughes: How do you do it?

Gumbiner: You give them a certain time to adapt, and if they can't adapt you get rid of them.

FHP's Competitive Edge

Hughes: Do you want to talk about what gives FHP a competitive edge?

Gumbiner: A competitive edge over whom?

Hughes: Over other health care systems.

Gumbiner: I can tell you what gives us the competitive edge over the traditional fee-for-service system; that is the fact that we're organized, our facilities work better, they look better, we're tuned into being in the service industry, not particularly to the medical industry, et cetera. An organized, managed system can always do better than a disorganized, unmanaged system, and people get more for their money.

I'm convinced that in the United States there's plenty of room in the whole medical care system to take care of everybody without costing anyone more money. We've already proven that in our Medicare program; we've proven it because we've done it. For eight years we've been supplying all the care that Medicare supplies for 95 percent of what the government pays for Medicare, plus we have removed the deductibles and copayments and have added prescription drugs, preventive care, and health insurance.

Hughes: Is anybody in government paying attention to that fact?

Gumbiner: They know about it in the Health Care Financing Administration [HCFA] offices, but they are under constant pressure by organized medicine, the hospital association with their twenty lobbyists up on the Hill, the AMA with their twenty-some lobbyists, the health insurance lobby, the people who manufacture expensive useless drugs and equipment, all of whom keep saying we're all wet. They say we must be taking only well people, which is not true, and that we're not giving care but just taking the money, which is also not true. There is a tremendous campaign to protect the status quo.

When you ask me what give us an advantage over our competitors, I have to think. We've probably got sixty competitors and each one is slightly different. Ten years ago we would only compete with Kaiser Permanente, and Ross-Loos until they were eaten up by Cigna, one of the IPAs. Now, everybody says they each have competitive advantage. From time to time we have had new people entering the field trying to buy the business. A big insurance company may convert all their insureds to an HMO, cut the premium price 20 percent, and go out and sell this to the employers. They plan to lose millions until they can put the competition out of business.

We don't always have a price advantage, but we think we have a service advantage since in our staff model we supply all care in one place and have our centers open twelve hours a day, seven days a week, plus we have a very flexible management staff. We have a number of different products and, in addition, we have the staff model giving us rapid market entry and

unlimited capacity. We're now working on a workers' compensation program that goes along with the same principles as our prepayment. We have our own health, accident, and life insurance company and we're hospital-based, which gives us an advantage over the IPAs. Although a pure IPA may claim that it has a greater choice of doctors and hospitals, it has less control over them--you pay your money and make your choice. It's getting to be like a commodity among the IPAs, deciding which corn flakes are better.

The whole HMO concept is so poorly understood, so everyone is struggling via their advertising and marketing departments to differentiate themselves from the competition and to deliver their message as to what they have to offer that their competition doesn't have. Whether the consumer believes that or not is like anything else--what has Toyota got over Mazda, or what does Mazda have over Buick, and so forth.

Hughes: Do most people really look that far? They don't just look at cost?

Gumbiner: Well, if we knew the real answer to that we could be right more often.

Hughes: For a lot of people it must be simply a matter of which plan costs least.

Gumbiner: I don't think so. Most ordinary insurance plans limit or exclude certain coverage so many consumers will look for coverage, such as OB or well-baby care.

##

Gumbiner: When you talk about the least expensive thing, you've got to compare what you're getting for what you're paying. The question is, why wouldn't you buy the cheapest possible car? If you only have to go from point A to point B in Los Angeles County, for instance, and you're not going to drive long distances, the cheapest possible car you could find would be the best for you.

Hughes: If it didn't break down.

Gumbiner: Why wouldn't you drive around in a Volkswagen Bug or a Jeep? Those cars are very reliable and never break down. However, some people drive a great big car, others drive a fancy car with different bells and whistles on it--it's a matter of choice, correct? If you consider medical care like an automobile, then you get the idea.

You can buy a cheap health and accident insurance policy, which won't cover for obstetrics, won't cover for well-baby care or immunization, and it will exclude a lot of different things. They give it to you in the big print but take it away in the small print. That is called underwriting (i.e., you write the policy). You will find that you may pay somewhat less money, but you may get half of what you're getting from somebody else.

The HMO, on average, can save at least 30 percent over fee-for-service. The advantage to the provider of care, first of all, is prepayment--you get paid a flat rate for each person covered the first of the month. We save at least 10 percent in collection losses, plus 10 percent in collection costs. The fee-for-service sector, even if there is insurance, there may be some balance billing or deductibles and copayments that you have to collect, which you can't collect because health care is a negative service. Nobody wants to be sick or think they will be the one who needs the care, let alone pay for it. One of the first things you have to learn about prepayment is, people will say that if you offer dental care everybody will come in and get all kinds of dental care. Well, do you think having a root canal on Thursday afternoon is a pleasant thing to do, even if it's paid for? [laughter] No, right?

Hughes: No, definitely not.

Gumbiner: Do you think having to take off all your clothes for a doctor and having him poke you, probe you, and look in all your orifices is something you'd like to do on Wednesday afternoon? No, because he might find something wrong with you, so stay away from him.

The idea is that we save 10 percent for collection losses right off the bat, and then another 10 percent is saved for the cost of collection. You send somebody a bill, they don't pay it, you've got to send them another bill, then you've got to send it to the collection agency, and so forth.

Then there is an indefinable amount, 10 percent or more, that you'd have to spend to market your services, whatever you're going to do. Whether you're going to spend extra time in community activities, whether you're going to have your wife entertain and have dinner parties, whether you're going to go to all the hospital meetings, et cetera. So, just what are you going to do, give lectures? You're certainly not going to sit in your office and hope that people find their way to you.

Hughes: But FHP also has to market.

Gumbiner: Right, we're marketing for our HMO doctors but in a coordinated effort with the advantage of the economy of scale. We do marketing but we take it out of more efficient services--we certainly don't have collection losses. Plus, we have the use of the money before we provide the service.

Then you say, well we have administrative costs. Everybody has administrative costs. You have to make payroll, you've got to pay rent, you've got to hire people, you've got to purchase supplies and equipment, which gets you back to what you started with. Do people select their health care provider or their health care system based on cost?

The employer would like to have the lowest possible cost, with no complaints--those are the two major items. They will pay a little bit more if they can have no complaints. The complaints drive them up the wall because they take a lot of time to settle, people are unhappy because the unions get on their back, and the employees blame the employer, et cetera.

Of course the patients would like to have personalized service, but then they would also like to have a Cadillac but only pay for a Volkswagen. We try to balance that, as I said before, we try to give the most care to the most people for the most reasonable cost.

Prioritizing Medical Care

Gumbiner: That gets you into another dimension--whether or not you're going to prioritize care and who gets what care. We try to take the position that we'd rather spend a defined amount of money in preventive care than in treating just a few people. We're always debating about who should receive what (who should have a hip prosthesis and who should not) and then set up certain criteria. In the fee-for-service system world, the criterion is can you pay for it? Anybody can have a new hip if someone pays for it, the patient or the insurance company.

Hughes: Now you say people are always debating, but who specifically is debating? Who decides those issues?

Gumbiner: The whole world is debating those issues.

Hughes: Well, within FHP.

Gumbiner: It's the medical staff that's always debating, and they set criteria or practice guidelines, such as, you don't get a new hip unless you're the proper weight. If you're a hundred pounds overweight, I can guarantee your hip will hurt. Maybe it doesn't need to be replaced; instead maybe the patient just needs to lose weight.

Hughes: What about age?

Gumbiner: That's another criterion. The question is, are you going to spend a finite amount of funds in giving an eighty-five-year-old person a new hip rather than immunizing the ethnic older population against the flu?

Hughes: Are you?

Gumbiner: My personal opinion is that you do not replace the hip.

Hughes: What does FHP do?

Gumbiner: To tell you the truth, I don't know what FHP does now in that instance.

Hughes: Are these criteria actually written or is this a matter of debate?

Gumbiner: I don't know if they're written or not. We used to try to write them down but people would throw them away all the time. We would write them down only to find some doctor who said he had never seen or heard of them.

We're always writing what we call "protocol" on how to treat certain diseases and certain conditions, what laboratory and x-ray work to do, other procedures to give, how you should go about treating various different diseases, and so forth. Some people don't get enough care and some people get too much. There is always a constant debate among our medical directors about what protocol is used, and if they should actually use the protocol.

One of the problems of managing physicians is, you can make all kinds of protocols, rules, and regulations and the physicians may not follow them, and then it's hard to figure out whether they did or didn't follow them. If we could just get the doctors to fill out their charts accurately and adequately we'd be happy.

Hughes: You must have a means of doing that--if you don't fill out your chart, you don't get your check.

Gumbiner: It's not that simple because some people hide the charts that they don't fill out.

Preventive Medicine

Hughes: You brought up a concept that I'm interested in--preventive medicine, which seems to me to be a very important part of any health maintenance organization--it's in the name. Can you tell me some of the specific ways in which you use preventive medicine?

Gumbiner: I've been through many conferences on what preventive medicine is, and to me preventive medicine is taking away the coverage and access barriers between the patients and the doctors. In the prepayment program we've always done that by eliminating or limiting the fee. If the person knows that the most he'll ever pay for an office call is five dollars no matter what tests or procedures are done, he'll go to the doctor. If he doesn't know what he's going to have to pay, he may procrastinate and not go to the doctor until he's seriously ill and ready for the hospital. There's an old saying among low-income people: "If I'm going to pay the doctor thirty dollars, I want to be thirty dollars sick." So by the time they get to the doctor they're not thirty dollars sick anymore, they're really sick.

Number one in preventive medicine is not just immunizing all the children. That's only scratching the surface. It is taking away the barriers to the individual getting into the health care delivery system that is important. Contrary to popular opinion, low-income people under-use health care; they don't over-use it if it's readily available. They've got more serious problems to think about, such as getting food on the table, repairing the car that is broken down, their son's in jail, whatever. They traditionally under-use health care and mostly because of the lack of health education on how and when to access the care.

The utilization of services has to do with the sophistication and education of the population as much as it has to do with age and sex characteristics. People who are more educated are more apt to perceive that they should get their ankle x-rayed when they sprain it, or that a cough may be pneumonia or TB, or to see a doctor if they have chest pains, so they will seek early care. Preventive medicine starts with health education.

Health Education

Gumbiner: Now I can go on about health education for another few hours. What is health education? I have a definite opinion about that too. I think health education should be done just like any other marketing program through advertising, promotional, or public relations programs. Use the most powerful medium we have, which is television. Don't sit around and hope somebody will come into your well-baby clinic so that you can hand them a pamphlet telling them you've got a well-baby clinic on Tuesday if they can find their way there.

Education is number one because even if you had the financial barriers taken away between the patient and the provider, patients have to be educated to know that they should go to the provider under certain situations. You know, "Oh, Dad just has a few dizzy spells but maybe he'll get over them" type of thing.

Then health care has to be accessible, convenient, supportive, comforting, and not intimidating. As an example, as soon as some of the underdeveloped countries became independent, they kicked out all their dispensary systems and built big, fancy, shiny hospitals and said, "Now everybody can come to the hospital and get their care." Even these emerging communist countries went to having much of their care delivered in the hospitals. They have an underdeveloped ambulatory care system, however. Everybody thinks babies have to be delivered by a doctor.

Hughes: And people don't come?

Gumbiner: They can't get to the hospital because there is no transportation, they can't find it, or it intimidates them. In the dispensary system in Yap, which the FHP Foundation sponsored, we have everybody immunized. On Saipan, where they did away with the dispensary system because the United States government built a shiny new hospital, 60 percent of the kids are not immunized. Enough said.

Preventive health depends upon health education so that you understand what bad health is and what good health is. In some parts of the world some people don't even understand that water might not be good even if it looks clean. It could have little animalcules in it. The guy says, "I don't see any animals. So what?"

Preventive health has to do with availability and appropriateness of health care services. Then you get into things like providing preventive prenatal and postpartum care, people not getting too fat, healthy lifestyles, and all the other things.

Hughes: How do you get that sort of message across?

Gumbiner: With difficulty. That's why we have a big health education department, which we're always feuding with because we get health educators in there that are poorly educated. They're educated by the universities in traditional health education. They haven't got the slightest idea about advertising and promoting. Some professors of public health teach them about health education--you run well-baby clinics by sticking posters up around here and there.

Hughes: So what do you do with them?

Gumbiner: I haven't got the slightest idea what they're doing with them anymore. When I was running the program I did all kinds of things. I put health education television in the waiting rooms, which failed because of poor content. I had health education carrels where, when the doctor diagnosed diabetes or hypertension, they had to fill out a prescription which indicated the patient had to watch this five-minute presentation on what diabetes or hypertension was all about. I also sponsored television, big public relations programs, and so forth. We're still doing the PR programs.

Hughes: Are you getting through?

Gumbiner: Little by little; inch by inch.

Hughes: How can you tell?

Gumbiner: You can't measure it. We would sit around by the hour wondering if our advertising campaign was successful. They say half your advertising money is wasted, but which half? Same thing with health education; half your health education dollar is wasted, but which half? If we knew which half, we wouldn't waste half, right, because we'd only use the half that worked. So we use all kinds of things--we have health fairs. Right this moment we have three or four different promotions. We sponsored a senior olympics in Palm Springs, we do television, and many other things.

I do believe, however, the American population, at least the educated, upper middle class, are slowly getting it. You

don't see too many ashtrays around anymore, and some companies are making a fortune out of sugar-free, fat-free foods--people are learning to read the labels. Everybody's struggling to keep their weight off and lead a healthier lifestyle. One thing they haven't promoted is that stress is the bigger threat to good health of all and they don't promote stress relief. We'll get there someday, but we've got to keep trying or we're not going to succeed. That's the end of my diatribe on health education.

Hughes: Well, it's a pretty good one.

Utilization Control

Hughes: FHP, I understand, has two or three different utilization control systems--one to control the other. Is that right?

Gumbiner: Actually, cost control starts with educating the physicians because they are the driving force behind whether somebody goes to the hospital or gets a certain treatment that may be necessary or unnecessary. Then we have some formal systems in which physicians have to get authorization before referring to a specialist in order to make sure that the referral fits certain criteria and that the physician is not just dumping the problem onto a specialist because he's too lazy to work the patient up. Then there is prior authorization for admission into the hospital for elective procedures and prior authorization for drugs that are not on the formulary.

We also have a concurrent review of all the patients in the hospital by our nurse coordinators in order to make sure that some doctor isn't leaving the patient in the hospital when he should be discharged. They also review patients in the hospital to see if they should be there. We also have another concurrent review by the pharmacy department on the appropriateness of the drugs that are being used in the hospital. Sometimes people forget to discontinue drugs, or they are using a drug when they could use another drug that is less expensive but just as effective.

There are a number of different fairly sophisticated utilization control programs. One key control is that you don't have days off. When some of the IPAs first started, the utilization nurse would take off on Saturdays and Sundays, or if she were sick there was no replacement. The key is continual attention and not letting down on any of the programs or letting them slide back.

- Hughes: I don't quite see the relationship with cost containment.
- Gumbiner: What are you talking about? Utilization control is cost containment.
- Hughes: What does being available at all hours have to do with cost containment?
- Gumbiner: If you have utilization control, then you must have utilization control seven days a week, twenty-four hours a day, since people are sick twenty-four hours a day, seven days a week, and should be getting care during that time.
- Hughes: Oh, I see. There was also a utilization committee?
- Gumbiner: The utilization committee evaluates procedures, forms, and policy. Of course the medical directors are all engaged in utilization control by evaluating their doctors in order to identify the outliers--the people that are way out of sync. The cost of prescription drugs per visit is either too high or too low, or they might be doing too many procedures that shouldn't be done.
- Hughes: Presumably there's a physician/patient ratio. How is that determined?
- Gumbiner: These days I'm not too involved in those operational management matters; I'm more involved in the theory and overall results. However, these ratios are usually developed from estimated patient visits and can be very involved when they are calculated by specialty.

Cost Containment

- Hughes: Do you want to say something more theoretical about cost containment?
- Gumbiner: Cost containment, fundamentally, starts with the doctors, is an ongoing process, and can never be neglected. People have to understand that doctors have different notions of what is and is not appropriate. You have to have certain standards to go by that everybody agrees on. Fundamentally, it is a problem of eliminating the waste and unnecessary procedures and treatment.
- Hughes: How did you educate new physicians to those standards?

Gumbiner: Well, with great difficulty. I really don't know how it's done these days, but we used to have orientation, continual reorientation programs, and all kinds of things to try to get their attention. At doctors' meetings we tried to see who could most closely tell what a procedure would cost or what a patient's hospital bill looked like. Most doctors who hospitalize patients have never seen a hospital bill and couldn't figure it out if they had to, yet they are responsible.

First, you've got to figure out what quality is. Is it quality in the eyes of the consumer, the patient, or the doctor? If anybody can figure that out, then he can get started.

Hughes: What did you decide?

Gumbiner: I know what my definition is but I'm not too sure everybody else agrees.

Hughes: What do you think?

Gumbiner: Since we are in the service business, quality is in the eyes of the person who is receiving the service or else they're not going to come back for any more service. Thus, you can't have a doctor sitting doing nothing. That's my philosophy.

Hughes: A physician practicing quality, not medicine.

Gumbiner: That's right. Reading a book. [laughter] On the other hand, many of the academicians think quality is having a bunch of letters after your name.

Hughes: And you never paid too much attention to that?

Gumbiner: What?

Hughes: Letters, degrees?

Gumbiner: All of our professionals are board certified in their specialty, of course, but board certification is just the beginning. There's a quality of service--where people think they're being treated right, they're in pleasant surroundings, people are pleasant to them, they think people are efficient, they get an appointment on time, and a thousand different things.

Hughes: What happened when there were instances of substandard medicine?

Gumbiner: What is substandard medicine?

Hughes: Well, below whatever you define as quality medicine.

Gumbiner: You give the physician, or whoever, a warning and bring it to his attention. It could be anyone from a lab technician drawing blood with dirty hands to a physician ordering the wrong lab tests. If they don't correct their errors, then you have to terminate them and send them back out into the fee-for-service sector where people have freedom of choice to choose or not to choose them.

Hughes: Is that enough on a big subject?

Gumbiner: Yes, I'm tired of that subject; it has been talked to death the last few years.

The Board of Directors

Hughes: How about the board of directors?

Gumbiner: There are volumes written on boards of directors.

Hughes: Well, yours specifically.

Gumbiner: Originally the not-for-profit prepaid community health programs were organized to have consumer boards of directors, based on the theory that the consumer could give input and control what and how these plans should produce care. I believe that is an erroneous concept and instead believe people who have expertise in management should be on your board of directors. By finding people from various industries who were experts in management but who also were being served by the health plan, I was able to conform to the theory without being trapped. Besides, no one was able to accurately define a consumer.

Hughes: Experts in anything, not necessarily medicine?

Gumbiner: Preferably not medicine.

Hughes: Preferably not?

Gumbiner: It's better to cross-fertilize with people from other industries. You start with the concept that there's very little good management in medicine today, pretty much like academia where there's very little management. I always chose people from different fields who could bring some new and different ideas, or who had some basic background that made them useful in an advisory capacity.

I also had another basic theory, that is, if people spend their time on board of director business, then you compensate them for their time. Even when I had a not-for-profit organization, I compensated board members for the time they spent on board matters, and I compensate board members by the year, not by the hour. Part of the payment is for their responsibility and part of it is for the time they spend on the telephone, reading material that is sent to them, in meetings, or in preparing for meetings.

Hughes: What do you expect of them?

Gumbiner: I expect board members to act as advisors and mentors to the management, and to protect the interests of the employees, the consumers, and the stockholders. They can give the company advice on decisions based upon their background and expertise.

Hughes: And did it turn out that way?

Gumbiner: Turned out fine. Historically, some not-for-profit organizations elicited community members, who had no management experience, to be on their boards to represent the community. That didn't work very well because they were being paid by the board meeting, so they would vote more and more board meetings so they could get paid more and more money. They didn't bring much to the table in the way of sound advice.

Hughes: I have some notes from a 1969 newsletter that said that the board of directors consisted of two members of the Members' Advisory Committee.¹

Gumbiner: That was in the old days. In the old days one-third of our board had to be community members.

Hughes: Who said that?

Gumbiner: I think it was in the 1973 HMO Act, something in the distant fog of the past.

Hughes: It was further back than 1973 because the newsletter is from 1969.

Gumbiner: The HMO, or GPPP, movement first started with a community-based nonprofit movement. Group Health Association, Inc., in Washington, D.C., and Group Health Cooperative of Puget Sound both started as co-ops, but they haven't done very well in the

¹FHP Newsletter, October, 1969.

rough and tumble competition that's going on today with the big insurance companies moving into the act. They're still back in history when they thought that all the good folks would get together in a co-op, hire good doctors, and they would all go down the road doing good things. But that doesn't happen without good firm leadership and management. It was more form than reality.

I organized a community advisory group which was composed of just members of the community we served, i.e. our enrollment. We weren't like the Watts Community Health Plan serving an undefined group of people; we had people who paid their dues and who were enrolled in the program.

Hughes: How did you choose specific members?

Gumbiner: I don't recall. They either volunteered (we chose a couple of the volunteers to be on the board), or they were referred. This was a simple problem; you just chose people that had expertise and happened to be enrolled members.

Hughes: Did they not necessarily give the sort of advice you wanted?

Gumbiner: No, you've got it backwards, that's the kind of advice I wanted. If you wanted a banker on the board, you found a banker that was enrolled in the plan and who was a community member as well. He served two purposes.

So community membership on the board was a big charade--stupidity on the part of the system--because everybody is a member of some community, right?

It all started with the cockeyed notion that these health plans would start in the poor areas (the poor people would serve on these advisory committees) and they would give advice to the health care people on how to run health plans. That didn't work. It's much more sophisticated now that we're a public company; now we have to go by the rules of the Securities and Exchange Commission [SEC].

The notion that you have community representation is at cross purposes with the SEC's notion that you have independent board members. Now, I can refer you to stacks of literature written on independent board members versus management board members: whether anybody can ever be an independent board member, whether or not it's desirable to have independent board members or board members who are insiders. The qualifications and compensation of boards is now a hot topic.

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- Hughes: Was there a problem, particularly when the HMO concept was new, of attracting physicians who leaned towards the left?
- Gumbiner: I think that you mean in attracting physicians who were more open to new concepts and caregivers, rather than being conservative and money-oriented.
- Hughes: There are physicians who lean to the left; I've talked to them.
- Gumbiner: Very few and far between. I've known a lot of people who are members of Physicians for Social Responsibility (I went to Mississippi with them in 1966) or were active in the civil rights movement, but social consciousness is not true of the majority.
- Hughes: Well, I'm not saying it's common, but it has happened.
- Gumbiner: What's that?
- Hughes: Kaiser had problems in the early days with socialists and, in some cases, card-carrying communists who were attracted to the idea of prepaid group medicine.¹
- Gumbiner: I never had that problem. There is nothing wrong with a variety of political ideas as long as they are good doctors.

Recruiting Physicians

- Gumbiner: Mostly people are attracted to an organization like ours because they want regular working hours, security, and time off. They don't want to have to run a small business, worry about credits and collections, and building a practice. Nowadays HMO physicians get their malpractice insurance paid for them and they don't have to deal with government problems. Some of the projections are that a vast majority of doctors who are coming out of school now want to work for an HMO or at least have a salaried job.

¹See the oral histories with Morris Collen, Clifford Keene, and Ernest Saward in the series entitled History of the Kaiser Permanente Medical Care Program.

In the early days we had to recruit people based upon a model of decent hours, steady income, and having backup. No matter what you do or say, when you're a solo practitioner, no matter how many kinds of arrangements you make with other solo practitioners, they don't work out very well because of misunderstandings, poor communication, and the fact that some people are irresponsible. The attraction of any group practice is that you avoid these problems. In a group practice, while patients don't always see the same doctor (because the doctor they usually see might be on vacation, doing postgraduate work, or out sick), their chart is there and another doctor in the group may be familiar with them.

The next step was extension of the group practice idea into group practice prepayment, combining the advantages of group practice with the elimination of fee-for-service.

My theory [of physician compensation] was to have it heavy on benefits and conservative on the direct salary because the more people made in direct salary, the more taxes they paid, and it got to be a little futile after a while. So I tried to emphasize the benefits. I worked out a system with our doctors, and all of our personnel for that matter, for a very generous pension plan. I think it was an additional 12 percent on top of their pay for all personnel, including doctors. I also developed a program, which not many other competitors had, where every doctor got two months sabbatical leave every five years. They had vacations that started at two weeks and built up to six weeks. At one time we provided them with a company auto after five years employment and gave them longer vacations and various other privileges as they gained seniority. We were able to recruit physicians with these advantages over fee-for-service, solo, or group practice.

The idea was that if you have long-term benefits versus direct compensation, people that are just looking for the highest compensation they can make before moving on to the higher paid position will not join your organization. In other words, you create a model that will cause the people who just want to join you and make some money and then leave to reject the job offer, either consciously or subconsciously. The model will attract the people who wish to be there on a long-term basis.

Actually, it is impossible to tell what kind of physicians will work out better in a particular situation since they don't really know if they want to work in a position they have never had experience with.

Hughes: You mean an HMO situation?

Gumbiner: Yes, or any kind of group practice or geographic location. If you clearly define the model to the person, they will consciously or subconsciously reject that model if they don't fit it.

Hughes: When did you present this model?

Gumbiner: In the interview. I told them our organization was run by a board of directors and a chief executive officer, who in turn appointed the medical director. If the doctor who is considering joining wants to join a partnership where he can get some modicum of control and share, he's going to reject this model, a corporate structure. That's good; we want him to reject it because otherwise he'll eventually become dissatisfied and cause trouble. He will get into the medical group and try to seize power.

Hughes: Did you lose a lot of people of that very point?

Gumbiner: I hope so. [laughter] I did a study with some people from the human relations department at UCLA in which we tried to figure out who would be the best suited physicians to join an HMO. We decided we couldn't figure it out. Therefore, we developed the theory of presenting a clearly defined model, and the person would reject that model. If you bring a person into a partnership inferring that all of the partners will be equal, they think they're going to become a partner and someday be head of the organization by just being a partner, or some other intrigue they'll work out. But, if you present a model where they can't do that, they won't join you, which is good.

For the same reason, you present a model where the doctor doesn't make a lot of money, but has a lot of indirect benefits and a better lifestyle. The person who wants to just make a lot of money rejects that model and won't join you, no matter how much you romance him. That's good, however. The whole idea is to clearly present the model so that an applicant doctor can make a choice.

Hughes: In your "President's Message" in the 1983-84 FHP Financial Report, you spoke about a new department of physician recruiting.

Gumbiner: I believe that is when we made the transition to a professional recruiting department. Prior to that time, along with some of the medical personnel, I used to recruit physicians. This was a very important step forward. Even today some health plans

continue to rely on their medical staff (i.e., department heads or others) to recruit their professional staff. Even universities do this. In fact, recruiting is much like any other marketing, which takes training and experience in that discipline.

Hughes: Up until 1983-84 you recruited physicians?

Gumbiner: Yes, I think so.

Hughes: By yourself?

Gumbiner: Along with whoever happened to be the medical director.

Hughes: How did you do it?

Gumbiner: Like anybody else, we'd advertise in journals.

Hughes: You weren't recruiting at medical meetings?

Gumbiner: Well, I had tried that without much success because I had neither the talent nor time for that approach. Once the recruiting department got going we'd use direct mail along with a few more sophisticated techniques, as well as regional visits and conventions.

Hughes: Was that largely a function of growth where it just got too much for you to handle?

Gumbiner: It was a function of growth, but it was due more to management sophistication. You get to the point where you need a specialized department to recruit, and so you put one together. However, it is important to note that the recruiting department prospected and closed the applicant, but the medical department would always qualify the applicant.

Hughes: The recruiting department became adept at presenting this model?

Gumbiner: Reasonably adept. However, they're salesmen and they're selling the company to the applicants; they're really part of the marketing department.

Hughes: Is there any sort of turning point when FHP began to be accepted by organized medicine?

Gumbiner: I'm not so sure that we have ever been accepted by organized medicine. It's just that resistance is no longer as overt. Perhaps it's a matter of organized medicine having lost membership and influence.

Hughes: Well, you are accepted today.

Gumbiner: Reluctantly.

Hughes: Well, you're getting plenty of doctors applying to your organization. That's one standard of acceptance.

Gumbiner: They're applying because they don't have too many alternatives and FHP has become more recognized.

Hughes: Certainly the static has decreased, let's put it that way.

Gumbiner: Some of the underhanded tactics are still going on, but it's less organized now. I would say that resistance is less virulent or aggressive than it used to be.

Hughes: One of the points you made in the interview with your daughter is that a doctor must treat the family, not merely the individual.¹ Do you want to comment on that?

Gumbiner: The doctor has to treat the environment the patient's in and not just the isolated disease. This goes along with the whole idea of quality of life included in the quality of care. This should be part of a doctor's training in medical school and beyond.

Management Strategy

Hughes: Please say something about management strategy when you were in charge.

Gumbiner: Management strategy and policy come in many formats and are defined differently by many people. They are essentially writing down in simple understandable terms what direction the company is going in and what it should look like at a future date.

Hughes: Well, I've got a quote.

Gumbiner: What does it say?

¹The unpublished transcripts of interviews entitled, "Health Care Today--Philosophy" (7/18/90), 159 pp., are on deposit at The Bancroft Library.

Hughes: This management strategy comes from FHP Health News, September/October, 1988: "To provide affordable, quality health care; to grow at a pace that won't outstrip financial and managerial resources; to cover costs through appropriate pricing, even in face of lower-cost competitors; to control costs by ensuring that every member receives adequate, but not excessive, health care."

Gumbiner: That's pretty good. Let me make a note of that.

Hughes: Who wrote it?

Gumbiner: I did. [laughter]

Hughes: No wonder you like it!

Gumbiner: I have to look it up and put it on the wall.

Hughes: Right, I thought it was pretty good. Does that say it all?

Gumbiner: That pretty much says it all.

Evolution Through Different Forms of Health Care Delivery

[Interview 5: February 19, 1992] ##/##

Hughes: Please comment on the changes in organization that FHP has undergone over time.

Gumbiner: FHP is one of the few organizations that has gone through the entire health care cycle. We started with a fee-for-service medical group. The fee-for-service medical group metamorphosed into half group practice prepayment and half fee-for-service. This mode was a failure because of the philosophical differences between the two. This is significant because people keep thinking, even in this day and age, that they can do prepaid and fee-for-service simultaneously with the same group of doctors and the same facilities. They find out that this cannot be done very successfully.

Since the fee-for-service doctor gets paid a fee for each service, the actual tendency is to encourage more services, in fact, to promote them. The doctor working on a prepaid capitation basis (office visits and procedures), since he or she gets paid a salary or a set amount, has a tendency to be more conservative and not attempt to provide more services. Just that difference in philosophy will cut a significant amount off the cost of care. It is significant that we had that experience with fee-for-service.

Then we shifted to 100 percent capitation prepayment. We became a not-for-profit organization in order to develop resources for incurred but not received claims liability at a time that we would have been taxed under another format.

When we were still not-for-profit, we moved from a non-hospital-based organization to a hospital-based organization and ran a tax-exempt bond issue in order to do that. The tax-exempt bond issue was the first step in public financing.

Subsequently, we moved from a not-for-profit to a for-profit organization and took the company public in order to attract funding, which we could not attract through conventional financing. One of the significant reasons for changing to for-profit was so that we could become a public company and sell stock in order to finance new facilities.

As we metamorphosed through all the different stages, we had to acquire more and more sophisticated management, and we had to become more sophisticated ourselves.

Marketing FHP as a Public Company to Potential Investors

Gumbiner: For instance, as a public company we have to go on what are called "road shows" to visit investors, usually to Boston, New York, and so forth, in which we have to present the entire company and its strategy in about fifteen or twenty minutes. This is done in order to convince people they should buy our stock instead of someone else's. We usually have a luncheon where we have between forty and fifty fund managers who give us probably an hour and a half of their time at lunch. It takes them half an hour to eat lunch, leaving an hour for the presentations. If you have three or four people making presentations, each taking five minutes, then add another fifteen or twenty minutes for questions and answers, you've gone through your hour.

Now, not only do we have to project into the future as to what our benefits and rates will be, as we did when we were not-for-profit, we also have to project for the people on Wall Street what our earnings are going to be on those benefits and rates. They want to know whether the quarterly earnings are in the ballpark with the company's projections. If they're way off, they become embarrassed and sell your stock, which then pushes the price down, which means that you cannot easily go out

and raise additional funds to build more hospitals, more facilities, or hire more people to do new and different things.

In public companies there's a continuing debate over whether you do things to control costs, increase the profitability of the program so it will look better the next quarter, or whether you don't worry about looking good the next quarter and spend the necessary funds so you'll look better a year from now. It is short-term action for short-term gains versus long-term action for long-term gains. Then there is the debate over whether you run the company to satisfy the appetite of the investment community, the long-term growth, or a combination. If at the end of the year the company does very well, the investment fund manager sells your stock because it generates a bigger commission for him.

But on the other hand, if we hadn't gone public, we could not have gotten the funds to expand the company. The first time we did the tax-exempt bond offering it worked out pretty well, but when we converted we had to raise money to pay off the bond issue. In other words, we had to retire the tax-exempt bond when we became for-profit and we had to go public to do this. We got a bridge loan and then went out with the first offering to pay off the tax-exempt bond.

Conventional lenders are not very interested in loaning money to tax-exempt organizations because there is no one to sign on the dotted line to pay for it if that organization disappears. Therefore, tax-exempt organizations have to float tax-exempt bonds that are sponsored by a state or municipality. That gets pretty tricky because it is difficult to convince these sponsoring organizations to take a chance on guaranteeing a bond. The best way to raise money, if you have a successful company and your stock is up, is to sell more shares to the public. This will dilute the stock and ownership of the shareholders and doesn't seem to bother the price in the long run.

Right now, as I speak, the health care stock of other HMOs and hospitals seem to be doing very well. In fact, they're twenty to forty times earnings, which is pretty spectacular. Usually, ten times earnings is considered reasonable. Whether they continue to do well or not no one knows. FHP stock is not doing as well as the rest of the industry because we are more conservative and not very exciting. The stock market investment community actually plays follow-the-leader. If someone who's knowledgeable in an industry is buying, they'll buy it. However, if somebody knowledgeable sells, then they'll sell also. The old joke is: the guy at the cocktail party says, "Oh

well, I'm leaving." The others say, "Oh, did he say sell?" Then they all run out and sell. [laughter]

When I talk to these people, my contention is that health care is a non-discretionary industry. In other words, if a person has a heart attack or a broken leg, he has little or no discretion on whether he's going to have something done about it.

The industry is pretty resistant to competition from overseas because it's not apt to have a bunch of Taiwanese doctors come in and take the place of the American doctors, whereas if you're a chip manufacturer you may find out that the Taiwanese are manufacturing your chip for half the price.

The investor decides that the health industry is a very good industry, like the food industry; that it is not cyclical like some of the high-tech stocks that are very popular one day but then when somebody invents another high-tech procedure, that obsoletes the first company. Then the investor asks himself, "Well, what part of the health care field should I believe?" The for-profit hospitals are fairly cyclical. They did very well for a while and now are doing poorly as the Diagnostic Related Groups [DRGs] empty their beds (as the federal government clamps down trying to reduce Medicare costs). As the federal government takes over more and more, there will be pressure placed on price control, causing the industry to become more efficient. Psychiatric hospitals were not subject to the DRGs. This means that the government only pays a flat rate for that particular procedure, no matter how many hospital bed days are involved, no matter how much money you spent on testing, or how many procedures you did. There are a lot of scandals in psychiatric care and in the substance abuse area in those hospitals and nursing homes.

Comparing HMOs and Medical Insurance Companies

Gumbiner: The investor gets around to the HMO field, which is a service industry and does not rely upon a product, and is in the business of delivering health care, unlike the insurance companies who only pay for care. The big difference between an insurance company and an HMO is, the insurance company will pay for health care if and when you can find it. However, if you have an insurance company indemnity card and you're in a place where there are no doctors to accept you or give you care, then your card is pretty useless, as is your insurance. The HMO

organization, on the other hand, not only pays for your health care but it supplies the health care as well.

The HMO is the provider of health care--the staff model more so than the IPA. The IPA is a joint venture between the HMO, the doctors, and the hospital to provide care. The staff model is a direct provider of care and probably the closest thing to an organization that both finances care (pays for it) and takes the risk. In an HMO the risk is entirely on the provider and not on the consumer. In the average health insurance policy, the risk is, to some extent, on the consumer. He usually has a percentage copayment, a cap over which the insurance company will not pay, and perhaps has exclusions on obstetrical care, on various disease or procedures, or on pre-existing illness. The difference is that the HMO's primary philosophy is to provide a stop-loss for the consumer. The consumer pays a surcharge of perhaps five dollars for each office visit and that is all. The loss is stopped right there because no matter what evolves out of that office visit, whether there is an x-ray, lab tests, or other procedures, the patient only pays five dollars.

On the other hand, if you pay a 20 percent copayment to an insurance company, you don't have any stop-loss other than a large cumulative stop-loss. It used to be that indemnity insurance companies would pay a certain amount for a procedure (some of them still do) and then the patient would pay everything over that. So, the insurance provides a stop-loss for the insurer and the HMO provides a stop-loss for the consumer.

Up to 1992, Medicare had the same problem--Medicare provided a stop-loss on payment. In other words, it would pay a certain amount for the procedure, and if the doctor didn't think that was adequate he would bill the patient over and above that. That's called "balance billing." That is being phased out now with the new regulations on Medicare.

One of FHP's philosophies is always to provide a generic prescription drug program--it's a stop-loss for the consumer. Depending upon the plan, the patient may pay three dollars or he may pay five dollars for any prescription. I haven't looked at the average prescription costs lately, but it's somewhere over fifty dollars, sixty dollars, and can go as high as eighty dollars. However, the consumer only pays his five dollar stop-loss fee. A patient could walk in with a ten-dollar bill and know that with the five dollar office call and five dollars for a prescription, he would walk out paying only that ten dollars. That's one of the advantages we have in our program.

Terms for HMOs

- Gumbiner: We also changed what we called ourself as we went along. We used to be a group practice prepayment, then we became a health maintenance organization, and now we're called managed care.
- Hughes: Is there any rationale behind those changes?
- Gumbiner: Yes, there is. Everybody's looking for a new image and they thought that group practice prepayment was too tired a phrase. It connoted in people's minds, perhaps, that they had to go to a clinic and take any doctor who was there. It wasn't true but that's what the perception was.

Strategies for Running an HMO

- Gumbiner: Two things that cause businesses to go out of business are underfunding and inadequate management. This is like a football team: if you just took eleven men with you on a game away from home it would be difficult to play another team with eleven men since you would have no substitutes. Or, if you took only one quarterback, and that quarterback got hurt, you would have to have another quarterback or have a halfback that could play as quarterback. There's an old saying, the team with the deepest bench will win the league. Thus, skilled management in depth is very critical.

Without adequate financing there is no margin for error-- you can afford few mistakes and no risk or growth. You can help underfinancing by a conservative approach and tough cost controls. One of the advantages of the IPA is that it doesn't need a lot of financing. It just needs an office with some administrative staff since it's actually using the facilities and personnel of the doctors and hospitals it joint-ventures with to produce the care.

The other thing that gives the managed care field a big advantage is the fact that it's prepaid. Fundamentally, you get paid before you deliver the service, which is unlike any other business. If you were to open a restaurant you would have to have the facility, equipment, inventory, and have it fully staffed before the first customer walked in. Your break-even point would be out in the future someplace, no one knowing where. If you want to manufacture a product, you have to manufacture the product and then sell that product, and

somewhere in the distant future you will hopefully make enough money to cover the losses in the first few months of setup.

In the prepayment field it's a continuum actually. On one end you have the IPA, with few facilities and staff costs, and on the other end you have the staff model. The old government-sponsored staff models (in the 1960s) thought they had to build the building and be fully staffed before they went out and sold the program. They consistently went broke, bankrupt, out of business, because by the time they got that all done they were so far in debt that they had a hard time financing the marketing that they had to do in order to get the program going.

Some of the employer groups that join HMOs have a yearly review cycle. You might sell them your program today but their present contract may not expire for three, four, five, or even six months, and you don't get paid a premium until that happens. You may have to be on a two-year cycle--you might miss selling a company the first year but you might sell them the second year, and so forth. Staff models have to be fairly conservative in the amount of staff they hire, the amount of facilities they build, and the amount of equipment they purchase prior to enrolling employee consumers. The skill lies in timing, that is, having facilities and personnel ready about the time that the consumer appears for service, not when they enroll.

When we took over the Utah Group Health Plan, that was their major problem. They had two facilities, they had staffed up, had very little in the way of management, and they hardly had any consumers to pay for all of that. I said to them, "You've got it just exactly backwards. What you should be doing is putting your money into the marketing, and once you know if your service is something that people want, then you can staff up." First of all, the plans usually don't start for two or three months after you've sold them. Second, people don't usually come in for service the first day; they have to get sick first. They don't all get sick on the first day they enroll so you're probably not going to get much utilization for three or four months. So, you really have six months after you've sold the service to develop the staff, establish the facilities, and set them up. You don't rent the facilities, develop the staff, and set them up only to wait six months for the first dime to come in the door. After about a \$5 million investment and a tremendous amount of effort, we made Utah into a successful HMO.

In Guam, the bishop was a very progressive person. He had set up the school system there and wanted to build a hospital. First he built the Catholic Medical Center, but he didn't know anything about physician management, a typical situation. He

thought physicians were all good people and they'd do the right thing without supervision, which would make everything fine. His physicians were not only moonlighting, they were daylighting. The bishop was paying them a salary, and for that salary they were supposed to be dedicating their entire time to the bishop's medical center. A patient would come in the door and the surgeon would say, "Ah ha, I think you have appendicitis. Meet me in the hospital at five o'clock after office hours." He'd be in the hospital, he'd do an appendectomy on the patient, he would bill him out of his home, and then take the entire fee himself instead of giving it to the bishop. What's even worse, he'd have the patient come back into the bishop's facilities and do the post-op work. That's what I mean by daylighting.

Originally, when we went to Guam, there were about five Filipino immigrant physicians. The surgeon quit and we fired one guy because he was incompetent, leaving us with three doctors. I said to them, "How much are you people getting paid?" And they said, "Well, the bishop's paying us \$20,000 a year." I said, "How much do you think you're making on the side?" They said, "About \$20,000 a year." I said then, "Tell you what, I'll pay you \$40,000 a year, give you a car, and a whole bunch of benefits (pension plan, health and accident, vacation pay), and you don't take any outside patients and don't bill on the side. Agreed?" That was just fine and they signed the contract.

Then I caught them billing on the side and I said, "What are you guys doing? We agreed you wouldn't do that." It took them about six months to realize that the deal they made was what they had. The dentists had all left, stealing all the moveable equipment on the way out--there wasn't a hand instrument left in the whole place. The only thing that was left was about two 500-pound bags of the stone used to make models for dentistry, and the chairs. We had to borrow burrs from the Seventh Day Adventists' group so that the dentist we shipped over there could drill teeth. So much for the good will of the dentists.

More on Medicare

Gumbiner: In the early eighties, Medicare only had about five or six pilot project programs before we started. As I told you, I spent about a year visiting all these pilot projects. Just as I had personally visited all the fee-for-service hospitals when I

wanted to build a hospital, I visited all these plans to find out the key to their success.

First, I found that some of them had serious financial problems while others had done very well. The groups that had done very well had spent a lot of money on marketing to make the concept familiar to people. They marketed to a lot of people in a hurry so they spread the risk. Those that had failed had just tried marketing to 1,000 or 2,000 people. Since they didn't do a multi-media ad and marketing campaign, they'd gotten just the sick people who were looking for a place to get all their care at little or no extra cost.

Second, you could not charge a premium. The ones that charged a premium failed because, again, those people who are willing to pay a premium are usually the sicker people.

Third, you had to supply prescription drugs. A doctor would see a patient with a mild cardiac decongestion. He would prescribe a diuretic; the patient wouldn't get the prescription filled because he didn't have the money to do so, or he would only get a half a prescription filled. So instead of one medication twice a day, he would take one medication once a day, and when he came back to the doctor he was really sick and had to be hospitalized. I've actually seen mothers who had children with a 104 degree temperature and you would see them come back in three days later and the child would be sicker and ready for the hospital. The doctor would ask, "Did you give the child the medicine?" The mother would respond, "No." When asked why she had not given the child the medicine, she would say, "My husband doesn't get paid until Friday." That type of thing is what we were putting up with. Now, when you have a kid that's hospitalized it's usually an exceptional case.

You have to spend a lot of money in advertising whether you have it or not because you have to get a lot of people in a hurry. In my first program we enrolled 10,000 people in about six to eight weeks.

Hughes: How?

Gumbiner: Multi-media advertising--radio, television, outdoor sign boards, bus boards, cab boards--you name it.

Hughes: Had you seriously taken courses in advertising?

Gumbiner: Oh yes, I've seriously taken dozens of courses and seminars. In fact, I used to teach management at Cal State Long Beach in their graduate school.

Hughes: Advertising was a component?

Gumbiner: Yes. No one every buys anything; things are sold to people.

When I was in my fifties, I decided, like many others, that it would be nice to either write a book, teach in a university, or go to a tropical island. I did all of those and, like everyone else, found there were problems with all of them.

You live on a tropical island and you get sick and tired of the sun coming up everyday and roasting you. You look at the coconuts until you go crazy since one coconut looks like another coconut. I tried that out in the Pacific in the many islands around Guam. I have visited tropical islands many times and they're all boring. How much scuba diving can you do? One reef looks like another reef, and one shell looks like another shell.

Then I tried the college professor routine for two or three years and got really tired of the politics within the usual collegiate setting. You always have a few people who are out gunning for somebody else's position, or one thing or another. Some spend more time politicking than they do teaching or researching.

Then I wrote a book in 1977¹ and found out that publishers are hard to get along with, plus they don't know how to market books very well. So, that's not a great deal unless you're willing to work hard at getting that book sold. You've got to get on that television circuit and sell your own book.

Expansion to Guam

Assessing the Need for a New Hospital

Hughes: Why did you decide to take FHP to Guam?

Gumbiner: How FHP got to Guam. I was out there scuba diving and a hospital consultant that I had talked to about building a hospital in the early seventies was asked to do a consulting job in Guam because a large architectural firm, specializing in hospitals, was proposing a 400-bed hospital for the Island of Guam. At that time there were about 80,000 people on Guam and they only needed a 100-bed hospital. This consultant told them

¹HMO: Putting It All Together. St. Louis: The C. V. Mosby Company.

that they needed a new system, not a new hospital, and recommended that they contact me.

They have a unicameral senate over there of twenty-one senators and the governor. Strangely, they had about twenty-two sites suggested for this hospital--each senator had a site that he wanted and the governor had his own ideas--so there was a big squabble.

Hughes: How big is the island?

Gumbiner: Twenty-six miles long and six miles wide. Their favorite pastimes are politics and saving face. This fellow, Robert Feller, called me up and said, "I told them that they didn't need a new hospital at all and that what they needed was a new health care system." I thought that was pretty interesting so I got in touch with a nun, Sister Jean Marie Menke, who was the business manager for the bishop, and we agreed to meet in Hawaii to talk about this proposed new hospital. I said, "Well, I'll pay my own way to Guam, look around, and just chat with some of you people." The sister went back to Guam and set me up with a long series of meetings. I took the all-night flight straight out of Los Angeles, about sixteen hours, and got there about five in the morning. She told me she had a breakfast meeting for me set for eight that morning, then a lunch meeting and dinner meeting that same day. This went on for three days.

I finally met all the people--the senators, the governor, the medical society, the hospital administrator, you name it. It became obvious to me that they didn't need a new hospital at all, and if they did need a new hospital it should only be a 100-bed hospital, not a 400-bed hospital.

After I finished talking to all these people, some of them said, "Well, what do you think?" I said, "I do not think you need a 400-bed hospital. The present hospital could be cleaned up and made do. But if you do build a new hospital, why don't you build a 100-bed hospital and build it right in front of the present hospital? You've got plenty of land." Whereupon they told me that they didn't want to hear that and that I should go away and never come back. [laughter]

Hughes: Why were they wedded to the idea of a 400-bed hospital?

FHP Moves In

Gumbiner: Image--the image of a big hospital. What they wanted was a monument, not a hospital. They were also trying to build a big airport that they couldn't afford.

About a year later I decided to take a business/pleasure trip and do some scuba diving in Palau and Truk, passing through Guam on the way. I stopped to chat with the bishop and the people on Guam and was told, again, that I should leave, that they didn't want to hear about a new system or smaller hospital. When I went on to Truk I got this frantic message on the Priestly Radio (the priests had a short-wave network throughout the Micronesian islands) that one of the priests had just received a message from the bishop that there was a big emergency in Guam and that I should return. I wondered to myself if somebody might have died at home or something. I couldn't get in touch with them right away because there was a storm on the island. In those days we didn't have satellite; we just had short-wave radios.

A couple of days later I was able to get through on Air Micronesia Radio and found that the big insurance company on the island, AFIA, which was a combination of Aetna, Fireman's Fund, and Travelers, had just raised the government of Guam's health insurance rates by 35 percent. Combined, these carriers covered all government workers, the state, city, county, and school district. They wanted to revise their health care system and turn it into a prepayment system, and could I come back?

Fortunately there was a Sunday turnaround flight (it was usually an every-other-day flight) and I was able to go to Ponape, take the turnaround flight, and get back to Guam. Whereupon they asked me and FHP to take over the bishop's clinic and provide care for all the government of Guam workers. The working population at that time was divided pretty equally into thirds: one-third worked for Guam, one-third worked for the feds (federal employees), and one-third for private industry. They wanted FHP to take over the whole system. I said I didn't think that was a good idea because if we had a monopoly, then the people would get upset with us. What we needed was something for the other doctors.

I had heard about the San Joaquin Medical Association's prepaid program when they put in their Medi-Cal program there, which was an early-on IPA prototype, and I knew how that worked. That was a program in which the doctors would bill against the portion of the premium they got. If their total billing was 10

percent in excess of the premium, they would get a 10 percent discount on each of their fees. If it was 10 percent less, they would get a 10 percent bonus, and so forth.

Health Maintenance Life Insurance Company

Presenting Dual Choice

Gumbiner: I told them that I would put that program together for the other Guam fee-for-service doctors and back it with an insurance company. They said, "Well, that can be the alternate insurance program." Fortunately, I had purchased the charter for an insurance company about a year before that and was able to qualify that insurance company on Guam, after I finally found the insurance commissioner in Guam--another story.

I had this idea of having a joint venture between the insurance company IPA and a staff model HMO to offer a dual choice. The HMO and insurance company combination was a unique idea in the 1960s on both sides--you'd get fewer benefits on the insurance side and more benefits on the HMO side, and there would be no discrimination in price. I had been working on this concept in California but had never been able to get it working very well. First, there was an insurance company covering their policyholders only through an IPA HMO, then this was combined with a dual choice staff model HMO--managed care.

Hughes: Were you the head of the life insurance company?

Gumbiner: Yes, I was the head of the insurance company, too. It took me about three years to get the charter, and then I had to get a million-dollar conventional loan, which I finally found, in order to charter the new insurance company.

Hughes: You knew about running insurance companies?

Gumbiner: I didn't know anything about running an insurance company, however, I took many courses on running an insurance company at that time.

Hughes: Crash courses?

Gumbiner: Insurance courses. I took a seminar in insurance company financing--deadly boring--a course in re-insurance, and about a six- or eight-week course just to learn the jargon and theory.

Hughes: This was after you'd created the company?

Gumbiner: While I was creating it and shortly afterwards. I did the same thing in data processing.

Hughes: Why did you think it was important to have an insurance company?

Gumbiner: I just finished explaining that. It was necessary to present the image of dual choice through a familiar vehicle, whether the consumer bought it or not.

Hughes: I know about dual choice, but not everybody was offering dual choice.

Gumbiner: You can't lock up everything. They either go to an insurance company-sponsored employer's program, where they can go to any doctor in any hospital, or to an HMO. When you have to have an insurance company offered alongside the HMO, it gives them the choice.

Hughes: Who says you do?

Gumbiner: I say you do. It's just common sense and everybody knows that. You can't just offer an HMO and put everybody in the HMO; that won't work. The employers figured that out and they didn't want to make their employees captive of an HMO. Those employees that don't get along with just any doctor are going to blame the HMO and then they're going to blame the doctor. You have to have an alternative for those people who are dissatisfied with the HMO. There's a certain number of people--we used to call "doctor shoppers"--who will not like any doctor. They continue to try to find a doctor who will agree with their diagnosis and treatment. Thus, you have to have a dual choice for that type of consumer.

When the insurance company is originally in on the case, it won't let the HMO in. In other words, it will insist that people have to disenroll from the insurance company in order to enroll in the HMO. The only way you can make dual choice work is to make a level playing field in which people have to make a new, mandatory, initial choice. If it is just an add-on program for the HMO, what happens is that for those people who are not sick and who don't go to doctors, medical care is not a priority and they will stay with the insurance program. The only people that opt out of the insurance program, during that little period of time that they can, are the sick people and so the HMO gets adverse selection.

In order to have that not happen, you should have a mandatory, new initial choice. In other words, you say to everybody, "You're going to have to make a choice of the HMO or the insurance company. If you don't make that choice, you won't have any coverage at all. Now here are the comparative benefits, so take a look at them." Now everybody is going to take a look at them, the sick as well as the well. It forces the people who don't use doctors to take a look, compare benefits and rates, and to make a selection. If you have a new initial choice you'll get a fair selection of people who want the benefits of an HMO and then those that don't. If you don't offer a selection, the insurance companies will do everything to hold down the HMO enrollment, such as you can only enroll in the HMO on the Fourth of July. We actually had that happen--the Fourth of July was on a Wednesday and the people were told, "During that week you can enroll in the HMO if you can find the brochure." [laughter] All insurance companies did that--they would try to keep the HMOs out because we were too competitive and offered too many benefits at the same price, or even less.

I tried to make arrangements with insurance companies for a "quota share" (insurance company jargon). In other words, both sides charge the same premium and each takes its share of the premium. We offered one product: the insurance company and the HMO, with different levels of benefits for one price. I must have spent two or three years trying to find insurance companies to buy into this idea. Well, if there is one group of people that are conservative, narrow-minded, and have gun-barrel vision, it's the insurance company executives and, as a matter of fact, they're still that way.

I finally gave up in total disgust. I could not find many who ran hospitals to my standards. I also could not find any insurance companies that were run to the standards that I wanted--that would give the consumer a break and would risk a new program.

Problems Finding Good Executives¹

Hughes: Did Guam revitalize Health Maintenance Life?

¹This and the following subsection were moved from their original position later in the transcripts of this interview.

Gumbiner: Well, it didn't revitalize it. It was a product that worked there and generated some income. I found that the insurance executives were a conservative group and not very aggressive nor very innovative. If you have a small insurance company, you have a hard time hiring a top-notch insurance executive because he can make a lot more money with a big company. I struggled and finally hired the number-two men of small insurance companies. First I hired a guy who was a general manager. As it turned out he wasn't able to do anything. Then I hired a man who was a marketing vice president for a mid-sized company who turned out to be a crook. [laughter] The marketing manager left the day after he rifled somebody's briefcase. Then I hired an insurance company financial guy who just got covered up with computer tape and never did anything positive.

Hughes: And Henry Schultz?

Gumbiner: Did I hire Henry Schultz for a little while?

Hughes: He told me you did.¹

Gumbiner: Well, maybe I plugged him in there for a short time.

Hughes: You did, and he was a bit surprised since he didn't know anything about insurance.

Gumbiner: He never did find out anything about insurance either. [laughter] I may have plugged him in while we were looking for somebody else.

I learned that the answer was not to hire insurance company executives, but to hire people who had never seen an insurance company. I called in a fellow named David LeSueur,² a very bright young man who was my assistant at the time. I said, "Hey Dave, how would you like to be president of an insurance company?" His face got white and he said, "I don't know about that. Can I have a day to think it over?" I said, "Yes, fine." He came back the next day and I said, "What do you say?" He said, "Well, I'll be president of the insurance company if you can reassure me that you'll get me a vice president of marketing." I said, "I'll have a vice president of marketing here in two weeks." He said, "I can't believe that." The man I

¹See the oral history in this volume with Henry Schultz, February 17, 1992; p. 392.

²See the oral history in this volume with David LeSueur, February 18, 1992, p. 300.

put in to be vice president of marketing was my son, Burke Gumbiner.¹

After Burke completed his undergraduate schooling he said, "I don't want to work for you." I said, "That's good." In a few weeks he came back and said, "I want to do the traditional thing and work for my father." [laughter] I said, "Why?" He said, "I can't find a job." I said, "I'm going to give you the worst job I have; I'll give you a job running a group of six black guys selling Medi-Cal door to door in the Watts/Compton area." He said, "I'll take it."

He was living with me for a little while until he got some money together to get an apartment. I asked him, "How come you're going to bed at nine o'clock every night?" He said, "I get those guys in the office at seven o'clock and they hit the streets at eight o'clock. If I look the least bit tired they jump on me like a pack of dogs." After a while I said to him, "Well, you look a little better. Did you solve the problem?" He replied, "Yeah, I solved it." I asked him what he had done. He said, "I lined them all up and told them, 'At the end of the week one of you guys is going to be gone, the one that is the worst salesman. And if anyone opens his mouth, he's gone now.'" I said, "What did they do?" His response was, "They all yelled, 'Right on, man, right on.'" After that he rode around in a pickup truck and they threw rocks at him. After he got over that he became an account executive.

I ended up sending Burke to Utah where he became the marketing manager. In Utah we kept the marketing director because he had contacts with the community, but he didn't do anything, and the marketing manager had to tell him what to do. We kept the medical director for the same reason--he was tied in to the university. But we sent him a chief of staff who called the shots.

So Burke went to Utah and became the marketing manager and sold a lot of plans there. Then he quit because he wanted to go back to school to get his MBA. When he got his MBA I said, "I'm not giving you a job. I think it would be bad for you. Go out and find your own job." So he was hired as marketing manager for some plan in Chicago. After he got an apartment and had it furnished, the plan folded three months later. So he called me up and I said, "Go find another job." He found a job in Oakland. He would call me up from time to time and say, "You

¹See the interview in this volume with Burke Gumbiner, February 18, 1992, p. 256.

know, there's something funny. The medical director and executive director are both quitting." I knew he didn't like that job too well, so I called him up and said, "How would you like to be vice president of marketing and sales for the insurance company?" I said, "I'll tell you what. I'll give you a company car, I'll pay you \$20,000 a year, and I'll give you half of 1 percent for all the new business you sign on."

Burke hired a bunch of castoffs from other insurance companies that were very aggressive and so he called them the "Dirty Dozen." He started selling \$1 million a month in new insurance. I said, "You're making too much money. I'm going to give you a quarter of 1 percent instead of half." He always took the attitude that we didn't need to talk about money. He would say, "I know you'll pay me well once you see what I can do." So he started to sell \$2 million a month.

Hughes: Had you cut his percentage?

Gumbiner: Yeah, I cut his percentage from a half to a quarter. But in the insurance business the more you sell, the more you lose because the insurance commissioner makes these companies set aside claims reserves of around eighty cents on every dollar they sell--the smaller and weaker, the more reserves. If your overhead is more than 20 percent, you lose money. In a small company, your overhead is a lot more than 20 percent until you get up to a certain volume, and then the bigger you get, the more it drives down your overhead as a percentage. You're spreading the cost; you don't necessarily rent more space for each person you add on. When you open up you've got to have computer services, you've got to have space, and you've got to have staff. Thus, you might be spending 90 percent on administration. Then the more business you bring in, the more that percentage shrinks. So, the more they sold, the more we went into the hole.

Then we lost our Utah FHP director (his two-year term was up and he left). So I had to move Dave LeSueur to Utah. Dave LeSueur is a Mormon and it looked like a good match. Burke had to take over as president and marketing director of Health Maintenance Life Insurance at that time. That was too much to deal with and, as I said, we were digging ourselves in a hole having to put up 80 percent of every dollar. We ended up closing the company but we didn't sell the charter; we just put the company on the shelf, and FHP paid off the entire tail.

FHP Life Insurance Company

Gumbiner: A few years ago we revived it as a dual choice insurance company.

Hughes: With a new name, FHP Life.

Gumbiner: With a new name. Actually it's done pretty well since we revived it.

Hughes: Why?

Gumbiner: Because we adopted a philosophy that we would offer a dual choice product, and we were lucky enough to get a reasonably experienced young insurance executive, Ed Zutler. The new philosophy was that we didn't expect to make money in the insurance company; we expected to use it as a dual choice product with the HMO and to do well on the combined product.

Our original mistake with HML was, I had the first insurance company adopt a prior authorization policy for hospitalization. (Now they are all doing prior authorization.) It did so well that we got the hospital bed days down to the equivalent of the HMOs. I said, "Gee, there is going to be a lot of extra money here so we'll add benefits--preventive care, prenatal care, and an annual physical." When we did this the doctors killed us through overutilization. We offered a \$100 annual physical, so when a patient would walk in the doctor's office with a cold, the doctor would tell him he needed a physical. Cling, they'd ring the old cash registers up to \$100. Although we had the hospital bed days cranked down pretty well, we had given too many benefits for the anticipated savings because the savings never materialized. It was essentially a mistake of inexperience in the ways of the medical world and we should have known better. We had put in a limitation on chronic repetitive disease (that is, the dermatologist having the patient come in once a week to take off a zit; the allergist having the patient have another test for immunization every week, et cetera). But the doctors were killing us. We were too liberal in ambulatory care.

Anyway, the insurance company has been revived with much more of a conservative insurance company approach. We are not anticipating making a lot of money--we simply want to produce a dual choice product.

Hughes: Any significance to the name change?

Gumbiner: I didn't really care to change the name but many others thought that would be a good idea in order to get rid of the old image.

More on FHP's Medi-Cal Program

Gumbiner: Just to digress, when we put in the Medi-Cal program, I sold this same idea to the state. They said, "We can't just have one offering, so we'll have a meeting and we'll ask all the HMOs and insurance companies to offer to cover Medi-Cal." We had a meeting in Sacramento between, as I remember, Blue Cross, Kaiser, Ross-Loos, and FHP. Cal West, the big state employees' program, said, "We can't do this because we have to study it and we have to be able to actuarially project this." The state of California said, "How long do you need to study the proposal?" The insurance company said (and I'll never forget this), "We think about six years," a little excessively long. Kaiser said, "We don't have room in our hospitals." And they are still saying that about Medi-Cal.

Hughes: Is that the real reason?

Gumbiner: I doubt it. Ross-Loos said, "We just don't want to do it." I said, "I'll do it." As it finally developed, FHP had a program, San Joaquin IPA had a program, the Sunshine Nursing Home had a program, and then an insurance company called Tri-Counties put together a program. We then had four prepaid programs for Medi-Cal.

The Sunshine Nursing Home dropped out pretty quickly, Tri-Counties dropped out after a year, and San Joaquin, who were only doing the doctors' part of Medi-Cal, stayed in for a long time. FHP stayed in for a long time and, in fact, just dropped our Medi-Cal program last year, after the state had only granted a 1 percent increase in rates for three successive years, which was a rate that was impossible to work with. First we dropped just Orange County because we couldn't render service for the increase that was being offered, and finally we dropped Los Angeles County.

Guam, Continued**Opposition From AFIA**

Hughes: You were talking about Guam. Maybe the next thing to talk about is the opposition to FHP coming into Guam.

Gumbiner: All right, I'll continue with that interesting little diatribe. We made an agreement to take over the bishop's medical center. He had a brand new medical center, about two years old, but he was going broke and couldn't pay the mortgage. He had a sister (a nun) managing it who didn't know anything about management. She thought keeping control was having the gold for the dentists' fillings in her pocket. If some dentist wanted some gold, he had to go find the sister. She'd dig in her pocket and give him enough gold for the filling. [laughter] Meanwhile, the doctors were robbing the bishop blind. We took over his medical center and it became the FHP Catholic Medical Center. We had to keep the crucifix on the wall for two years.

Hughes: That was part of the agreement?

Gumbiner: Part of the deal, right. In any event, when AFIA heard we were coming to town, they dragged in their general manager for the Western Pacific to take over. They decided they would reduce their rate to what ours was and increase their benefits to what ours were, including prescription drugs, hoping to drive us off the island--that was the idea. There were "carpetbaggers" coming in with the doctors from California and they had all the local doctors lined up to support them. There must have been twenty-five or so organized into a loose, poorly controlled IPA.

Hughes: Were these Filipino doctors?

Gumbiner: They were a mixed bag. There were probably half a dozen Haolis, as they called the people from the States, that were sort of expatriates, and the rest were a mixture of mostly Filipino doctors, a few Chinese doctors, and maybe an occasional Taiwanese or Japanese doctor. Guam didn't have any doctors after World War II; they had 10,000 people and a devastated island.

Shortly thereafter they began recruiting doctors from the Philippines to work for the Guam Memorial Hospital on a two-year contract. The Filipinos had a lot of doctors and nurses, many of whom were trained in non-qualified institutions. After their two-years obligation, they would quit working for the Guam

Memorial Hospital, set up a practice, and then proceed to rob the citizens of Guam. They would charge outrageous prices and take their land if they couldn't pay. When we got there, you couldn't find a single Filipino doctor on Wednesday afternoons because they were all off playing golf. And on Saturdays and Sundays you couldn't find them either. A patient had to go to the hospital emergency room, where they were treated by some other hospital-contract Filipino doctor.

So, AFIA was going to drive us off the island--really hilarious. The doctors all went out and recruited back their patients into their plan for AFIA. They recruited the patients that were lying in bed in the hospital; they recruited the patients they saw who were sick, and so on. They didn't see well people, so they didn't have a balance and they didn't have any spread of risk. They didn't have a generic formulary either because the doctors didn't like that. They could prescribe anything. There was no constraints on what they could bill or how much work they could do. At the end of the year, AFIA had lost over \$1 million that they knew about, and they didn't know about the several other millions that hadn't been billed yet. They took their manager and stuck him in some small place in west China, I think. They eventually collapsed the business and left the island.

At that time the government of Guam came to me and said, "Well, we want you to take the whole thing over." I said, "I can't do that because you'll have some discontented people who will not be content with just one HMO on the island."

Hughes: Discontented doctors?

Gumbiner: No, discontented consumers that don't like any doctor because they don't like being sick--that's the basic philosophy. You don't usually deal with happy people in this business because they don't want to be in the hospital in the first place, and they don't want you examining and treating them in the second place.

I said, "Okay, I'll bring HML Life Insurance Company," which I had up and running by this time. I couldn't find the insurance commissioner to get a license, mainly because he didn't exist, so the bank commissioner took care of issuing the license. It took about a day to get the license. We signed up all the doctors, and we were running our own competition.

Hughes: Now that was an IPA?

Gumbiner: Right, exactly. We basically just did what San Joaquin Medical had done with the total premium. We took a percentage for the hospital, a percentage for the doctors, a percentage for prescription drugs, a percentage for administration, management, and marketing, and the doctors billed against their pool. In other words, whatever the doctors' percentage amounted to, they only got the number of dollars they billed against that pool.

The one difference was, I drafted into the contract that each month the doctors started over. (San Joaquin set the doctors' percentage of their fee schedule on an annual basis.) Say they had a bad month, had billed more than the pool, and took a 20 or 30 percent discount. Well, that only lasted for that month because the next month they could start over and, if they were careful about running up their bills, they could get a better rate.

Then they complained, "Well, the month that we have a good month I'm off-island on vacation, and the month we have a bad month I'm here." Then we put in a three-month rolling average--we would add a month and drop a month. That worked along pretty well, except we were too successful. We were a victim of our own success and eventually we had the competition copying us. I must say, we did revitalize health care on the island. We came in and opened up the bishop's clinic to operate twelve hours a day, seven days a week. And guess what the other doctors did? They suddenly became available on Wednesdays and weekends; they formed a couple of groups and cooperatives.

Negotiating with the Physicians

Gumbiner: Negotiating with the physicians was a real arm-bender because I had to get the doctors signed up, and they didn't want to sign up in our program, the FHP IPA program. I got them to appoint a negotiating team of three doctors. We negotiated often until three o'clock in the morning. In those days there were no computers or word processing, so I'd have a typist sitting outside typing sections of the agreement as we negotiated. The negotiating committee then made a presentation to the rest of the doctors, telling them that they had studied and negotiated the contract and that everybody should sign it.

It was hilarious! There were three exits to this meeting room. I had one of my people at each exit with a pile of signature pages to the contract. These doctors started milling around, circling around, trying to get out of the room by one of

these three exits without signing. But every time they tried somebody would hand them a piece of paper. Finally, one of the men on the negotiating committee grabbed a contract and said, "I'm signing it and I'm signing for all my partners." When he did this, they all signed.

We went on our way and everybody did fairly well. We reduced the cost to the government, reduced the cost to the people, increased the availability of care, and got a better quality of care from the doctors because we were able to review their charts and see what they were doing. If they were doing strange procedures that they shouldn't be doing, we told them we would not pay them for those kinds of procedures. For instance, we had one doctor, a pediatrician, who claimed he saw eighty patients a day. I said, "If you see eighty patients a day, in an eight-hour day you wouldn't have time to go to the bathroom." There was no way he could see that number of patients in an eight-hour day. We found out that if there were four kids in the family, he'd drag them all out of the pickup truck, look in their throats, give them all shots, and then charge for four long office calls. Sometimes he would just have his nurse give them injections and he would charge them for an office call.

One doctor, Dr. [Ernesto] Espaldon, was off-island and came back the last day I was there. I was leaving on a three o'clock plane. His nurse called me that morning. I called him back about noon or so but he was out. I said, "Well, I'll be around until about two but then I have to catch a plane. Please ask him to call me." The nurse never gave Dr. Espaldon the message so he thought I hadn't called him back and he lost face.

This doctor, who was also a senator, made it his business to start another HMO to compete with FHP. He'd already tried to start two plans and had failed. He had also tried to build a hospital, he had tried to build a medical group, and he couldn't do any of these things. He wanted the government of Guam to form a competing HMO, but the senate wouldn't vote for that. He was also on the board of directors of the Guam Hospital, so he got the hospital board to set up its own HMO. In cahoots, the chief of staff told the doctors that if they didn't quit our HMO and join his, they were going to lose their hospital privileges, and they should bill FHP and HML as much as they could to try to make them go broke. We had nurses that overheard these two individuals talking about this. The upshot of all that was, Dr. Espaldon had a meeting with all the doctors in the Hilton Hotel.

The next day, Sunday, there was an ad in the newspaper saying that all the doctors quit HML, our IPA HMO. We then received identical letters from the doctors on an attorney's

stationery saying they were resigning that day, no matter what was on the contract.

We sued them for \$200,000 each for unilaterally breaking their contracts. It had been a one-year contract and the dates were all staggered. They had agreed to give us thirty days notice before the end of the contract if they wanted to quit. They considered that thirty days notice just anytime they wanted to leave. In addition, the agreement provided that they would have to care for the patients covered under their contract until the end of that particular contract period. It took us about six months to work out of this, but we didn't have to leave any patient in the lurch.

They wanted to know why I was suing them, so I traveled to Guam again and invited them all to dinner to have a little chat. After the meeting, they all decided to sign up again. I also sued Dr. Espaldon, plus the chief of staff of the hospital, for interfering with our contract. Interestingly enough, these twenty-some doctors all had "collective amnesia" regarding any meeting or conversations on depositions. That suit dragged on for a number of years and finally they tried to get the suit thrown out because of inactivity. I told my attorney that I wasn't really interested in the suit anymore--it had been dragging on for so long--and if we could get a guarantee from Dr. Espaldon that he wouldn't sue us for malicious prosecution, we would just forget it.

Well, this crazy lawyer got a verbal promise from this doctor's lawyer that they wouldn't sue for malicious prosecution. The attorney signed off and then the doctor sued us for malicious prosecution! He is still trying to sue me fourteen years later. The latest thing is that all six judges on Guam have sequestered themselves and have decided they have a conflict of interest and will not try the case. As it stands now, they can't find a judge to try the case.

That's not quite the end of that story. The Guam Memorial Hospital Health Plan (Dr. Espaldon was its director) hired some woman to run the program. This woman was last seen going over the hill, one step ahead of the IRS, jangling her gold jewelry. They were doing crazy things; they would charge their own health plan five dollars a month for each person for all hospitalization, all outpatient care, and all emergency room services, and then charge us fee-for-service--an obvious and gross conflict of interest.

I filed an antitrust suit against this plan because they were the only hospital we could use, and it was an unfair trade

act--they were discriminating. They went to see their antitrust lawyers in Honolulu, who told them they had a bad case. We thus negotiated with them in Honolulu and gave them some extra money. They agreed they would charge each one of the health plans, theirs and ours, on an equitable fee-for-service basis. After reaching this agreement, they proceeded to charge their health plan but had no intention of collecting from it. So we had to reinstate the suit to get them to collect from their health plan, which they never fully did.

Dealing with the Bishop

Gumbiner: Meanwhile, there was another process going on with the Bishop of Agana. He decided that he couldn't stand a run-down government hospital and he wanted to build a new hospital. He secured a loan from Aetna Insurance company, leased land from a nunnery, and pledged the cathedral and the Catholic school as collateral on the loan. Wonderful, huh? [laughter]

Hughes: Yes!

Gumbiner: The bishop went along trying to get this hospital built and had it about half built when Aetna Insurance Company said it would not give him the last draw on the loan (to pay the contractor) because he was trying to build the Mayo Clinic of the West, as he called it. Aetna kept asking him where he thought he was going to get the specialists to come live in Guam in order to do this. Bottom line, he could not make the loan payment.

I redesigned the whole first floor for him so he could turn it into a prepayment medical clinic and urgent visit center, and got rid of some of the fancy procedure rooms, special x-ray facilities, and other nonessential items. He received his next draw based upon my plan budget analysis and description as to how to develop prepayment income. Then he threw away my whole idea and proceeded to build his concept of the Medical Center of the Western Pacific. When the contractor finished building the hospital, the bishop could not afford to equip, staff, or open it. They had to do something else then.

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Gumbiner: A group of Koreans came in, headed up by Father Moffitt, who was not exactly a Korean--he was an Irishman, and a real character. He had been in Korea when the Japanese invaded and they placed him in solitary confinement for three years. Father Moffitt was

sort of a fat guy and said it was because when he was in confinement for those three years he would watch a hand come into his cell once a day with a bowl of rice and he swore he would never deprive himself of food after that (or women as it turned out)--he was sort of a renegade. He and another married priest he had with him took over control of the bishop's hospital and in return staffed it with Korean specialists and Korean equipment. Of course the beds were made to accommodate the size of a Korean and were a little short for Americans. [laughter] Politically, it got to be pretty bad because then the bishop said to me, "We've supported your health plan and I think you should put all your patients in the new Catholic Hospital now," that is, all the federal and GovGuam patients. In the meantime, the governor's office called me up and also said, "The governor thinks that since you have this big contract for GovGuam employees, you should put your patients in the old Guam Memorial Hospital."

I went out there once again to try to solve this current problem. I made a Solomon-like decision, that is, I would put half the patients in the Guam Memorial Hospital and half in the new, poorly equipped, Korean-run, bishop's hospital (Medical Center of the Marianas). It finally got so bad at the new hospital, Father Moffitt told me that if I would give him the prepayment ahead of time, he would issue the checks to his employees on Friday after the banks closed, and he would take the money and be at the bank's door on Monday to cover the checks. Anyway, the bishop went bankrupt through the manipulations of the guy that was suing me, his HMO, the Guam Memorial Hospital, and the government of Guam, and the bishop's hospital eventually went broke.

The government of Guam then squatted in the bishop's hospital; they just moved their entire staff out of their hospital into his hospital and didn't pay anybody anything! Finally, it ended up that the United States government paid off the Aetna loan of some \$23 million--pretty good bargain--and GovGuam had a new hospital. It had been built to conform to American standards and lifestyle. It had outside stairways for when the typhoons came, which was with regularity. The storms would shut down the electricity and elevator, and no one could get up the stairways in the downpour because it would blow them away. There were a few major problems like that which made it difficult.

The GovGuam Hospital went broke from time to time (that is, their annual expenses were in excess of their income). They are doing pretty well now because they have an influx of tourists,

but the tourist business is cyclical. Their major problem is political interference and poor management.

Hughes: What about the Seventh Day Adventists?

Gumbiner: They had their own little program there.

Hughes: No relation to yours?

Gumbiner: Oh yes, they joined our IPA. I talked to their head doctor, Dr. Olsen, and said, "What's the problem about joining the IPA?" He said, "We're here to do the work of the Lord--but the rates are not high enough." [laughter] I'll never forget that. I just sort of looked at him and said, "I've got it; I've got it."

They live and work in their own isolated compound, a cinder-block clinic, and change their doctors and managers every two years. They go out on a mission for two years and then they change, so they're not that popular. Dr. Olsen is doing the work of the Lord. [laughter]

Recruiting Physicians

Hughes: What were you doing for doctors? Were the local doctors sufficient?

Gumbiner: No, we shipped doctors in from all over. We have about twenty-six doctors on Guam now.

Hughes: That you recruited or transferred?

Gumbiner: We sent them from the mainland.

Hughes: Yes, but did you recruit them fresh for Guam or were they transferred from positions here?

Gumbiner: Some of each. It was a very simple program, which I espouse for the United States in order to solve the problem of caring for rural and inner-city areas. We have doctors go to Guam for two years, we pay them a 10 percent bonus on their salary, we give them a car (we rent little Datsuns or something like that), and we give them a couple hundred dollars extra living allowance. They get to go to Guam where they're two and a half hours from Tokyo, two hours from Manila, two hours from Taipei, with lots of good scuba diving, sunshine, and sailing--a great opportunity. As a matter of fact, I think we have a somewhat

higher quality physician in Guam than we have anyplace else because we have a more liberal, more adventuresome type of physician there. Of course, we also have a certain number of people who are trying to get away from bad marriages, or one thing or another.

At one time we had four medical school professors. The doctors that went to Guam tended to be older physicians that had practiced a long time, taught a long time, and had decided that Guam sounded like an interesting place to be for a while (usually with a new wife). They did a very good job. They were a very close-knit group, had their own parties, went on hikes together, and various other activities.

Hughes: How did they integrate with the Asiatic physicians?

Gumbiner: Not badly. We brought in some of the first qualified specialists on the island. We established an annual postgraduate seminar on the island for doctors and medical personnel and brought in speakers from California, Hawaii, and from around the world. I think we are in the sixteenth or seventeenth year of that program now.

Hughes: On what kinds of topics?

Gumbiner: I could probably get the agenda for the last few years, but they generally speak on various medical topics. I think it is a two- or three-day seminar and we have had up to fifty attendees, which is most of the medical personnel in the Western Pacific.

I learned that USC [University of Southern California] was sending a group of medical school professors to Hawaii to conduct seminars each summer. It was one of these deals where these professors would go to Hawaii to give a seminar, and it seemed simple to me that some of them should just as easily proceed on to Guam. It was with a nucleus of those professors that we set up the first FHP seminar. Last year we invited a surgeon from Japan and other Pacific Rim countries to the seminar. These are mainly professors from the United States.

Hughes: Was the experience with the IPA on Guam giving you ideas of how you might use the IPA on the mainland?

Gumbiner: Yes. This was a very valuable experience. I don't think we have changed our policy on the IPAs very much since then.

Expansion to Utah

Taking Over the Existing HMO

Gumbiner: When do you want to talk about taking over the existing HMO in Utah, Utah Group Health Plan?

Hughes: I want to talk about Utah now.

Gumbiner: Utah was a similar situation. I used to go skiing in Utah. The government had a pilot project in Salt Lake City, Utah, a staff model HMO. I went to see it and it was all discombobulated and not well at all. I asked if they needed any help and, of course, they gave me the same song and dance I got everywhere, "Forget it, we don't need you because we know what we're doing."

I had a market study done by a friend of mine who was a professor in the Department of Health Sciences at the University of Utah, Carmen Ness, so I knew pretty much what Salt Lake City was all about. A couple or three years later I met the chairman of the board, Irene Sweeney, and the executive director of Utah Group Health Plan, Diane Moeller. They let me know their organization was within ninety days of running out of money and could not meet their payroll. The Utah Group Health Plan terminated the executive director and turned over the management to Hilmon Castle, M.D., the head of the family practice department at the University of Utah Medical School. Of course that didn't work because not only was he practicing cardiology and head of the family practice department, but was trying to be the director of this HMO all at the same time. Then they assigned a former Catholic sister hospital executive, Diane Moeller, who was working in the family practice section, to be the new administrator. She took one look at what was going on, and she was pretty sharp, and said, "This place is going broke." Indeed it was.

By happenstance I met them at a meeting we both attended and we got together to talk about this failing plan. This conversation eventually led to a statutory merger. We were still nonprofit, they were nonprofit, and with a statutory merger we took over the program. Five years into managing this plan, and after putting about \$5 million into it, we finally turned it around.

We never have experienced the vicious doctor animosity in Utah that we have experienced in California and Guam, probably because they have a different organization in the Mormon

community. However, we are now getting a lot of tough competition from the LDS [Latter Day Saints or Mormon] Hospital chain and the Intermountain Hospital chain. Those organizations have put together an HMO to try to compete with us and fill their beds since we're not using our hospital.

Hughes: How recent is that?

Gumbiner: They've been competing with us for probably the last five years.

Making Changes

Hughes: What sort of changes did you have to make in Utah?

Gumbiner: Everything. When we got there they had a bunch of doctors who wore hiking boots and denims to the office and were being underpaid and weren't working. So, needless to say, we immediately had a little problem. There were about ten doctors at that time and they said, "We all quit." That's standard. Right? I said, "There are ten doctors in California that we can bring in. In one hand they are holding a Utah license and in the other hand they're holding their airplane tickets." [laughter]

Hughes: Which wasn't true.

Gumbiner: Not exactly, but I probably could have done it. I said, "You want to talk about this?" One of them reached down and put a bottle of brandy on the table and said, "Let's talk about this." So I said, "What do you guys want?" They said, "Well, we want to be paid like the doctors in California." I replied, "Then you're going to have to dress and act like them. Start by taking off those hiking boots and denims and begin to look like doctors." We went around and around about that. We fired a few of them. Some of them quit, but we replaced them.

They had two medical centers, which were totally inefficient, so we remodeled them both to make them more efficient. One of the centers was in an old county hospital and people told me I could never sell that to the middle-class consumer. We fixed it up, made it look good, and we sold it just fine. In fact, it was a very busy center.

They had also purchased a site in south Salt Lake City where they built two pods. They were built by a prize-winning architect but they were nonfunctional. That center had single-

glazed windows; heated up in the summer and froze in the winter until you couldn't stand it. The space was poorly utilized, and there was no patient flow. We had to redesign all of that. Now we've added two more pods to that complex, making four or five pods. We purchased more land after a while and now have about eight or ten centers in Utah, and we are building a hospital there.

Dealing with the State of Utah

Hughes: Was marketing to a conservative population a problem?

Gumbiner: Not really. I went to see Governor Calvin Rampton and his attitude was pretty indicative--he was smoking a big black cigar (a nice Mormon guy). I said, "Governor, we've got a situation here in which we can offer more health care benefits for less money for the state employees." He took a big puff on his cigar and said, "I'm for anything that's a good deal." [laughter] I said, "What should I do?" He said, "You go downstairs and talk to the state treasurer." I said, "Good." I immediately went down to the state treasurer's office. In their enabling legislation, which some good folks had gotten me, was a little clause that said that any group of state employees was entitled to join an HMO. I said, "The governor says that he thinks this is a good deal and that the state should allow state employees to join the HMO." The state treasurer's office said, "I'll look into that." Nothing happened and we could never get to first base.

It turned out that the state treasurer's wife was on the board of directors of the insurance company that had the state employees' contract. This fellow alleged that he couldn't allow us to enroll the state employees until he had an interpretation of what the word "group" meant, and that the definition would have to come from the attorney general's office. The legislation stated that any group of state employees was entitled to join an HMO.

It so happened, the attorney general was running for governor and the person that was doing our public relations was chairman of his finance committee. She arranged for me to see him and I said, "I think you'd make a fine governor but we have a little problem here. We've got this letter from the state treasurer requesting a definition of the word 'group' that seems to be stuck in your office." This guy says, "Oh yeah? Who's got the case?" He called the man handling this and said, "What

about this?" There was silence and finally he said, "What do you mean you can't find it? I'm sure you can find it, and I'll call you back in five minutes." He called the man back in five minutes and said, "You figure this out yet? You've got the definition?" The other guy said, "I got it. A group is more than one person." The man in the attorney general's office said, "Okay, good. Would you put that in a letter and get it up to my office today?" So that was the end of that. [laughter]

Hughes: FHP, at this point, was located in three geographically distant areas--Guam, southern California, and Utah.

Gumbiner: And New Mexico and Arizona.

Hughes: Not yet. I'm talking about the mid-1970s. What problems did administering a Utah and Guam operation from southern California present?

Gumbiner: It wasn't too tough. We just set up certain standards and decentralized, but of course Guam was naturally decentralized.

Evolving Tables of Organization

Gumbiner: As I said before, you have to constantly reorganize your table of organization for a changing environment. That's why I developed the matrix idea. I found that as we had metamorphosed through the different stages I mentioned before, we also moved through different types of tables of organization, which is not too unusual.

In the beginning I was a one-man band. I was the medical director, the marketing director, the operations director, the finance director, the sales and P.R. director, et cetera. I decided that I had to make the jump and start hiring. First I hired a marketing person, a financial person, and an operations person. At that time they were reasonably unsophisticated; the operations person had been my nurse (I had sent her to a lot of clinic managers' courses), the finance man was a standard accountant, and the marketing man was an ex-beer salesman. The key here was that I hired the staff before I could afford them so that they could develop and manage. We started out with the little staff I just mentioned and then, over the next few years, developed a number two person in management to help me with the management.

After I left that momentous meeting with my partners in 1966, when they all walked out on me, I was able to move forward and staff up on management in a more planned manner. I believe the key in the development of FHP as it is today occurred when Plaza Medical Group broke up. My partners all left because they wanted to return to pure fee-for-service practice, allowing me to develop the group practice prepayment concept, the management structure, and financing policies, unfettered by their unsophisticated, naive attitude.

Teaching at Cal State, Long Beach

Gumbiner: As I began to develop the management staff, there was the question as to how in the world I could recruit managers. In those days no one wanted to go into the management of health care field because they didn't know what it was all about. It was perceived as just a field for doctors and nurses, plus there was no money in it. All that the graduating MBA [master of business administration] students wanted to do was go work for a big corporation or in the financial field. The universities had campus career days where all the big corporations would show up to interview the students, and what was I going to do to compete? There I was, a lone doctor trying to recruit people to work in my medical group. I asked myself who would know the good students. I figured that some of the college professors would know them. However, students can con college professors. Other students would also know the better students.

I thought it would be interesting to teach at the state university and maybe I could recruit some good people, which I did. I taught a graduate school seminar in health care management and anybody that got an A in my class would receive a job offer from me. Of course the chairman of the department accused me of commercializing his business school. That seemed odd to me. I said, "What are you talking about? If a student gets an A in my class, I'll offer him a job but he doesn't have to take it." I did get some of my early managers from this source and I got one individual from a professor I knew at UCLA. After I recruited a few of these people I said, "Hmm, now these people have to be trained in the real world."

Finally, after three years, my very popular program was dropped from the curriculum because of political maneuvering of other faculty members. About that time I wrote the book, HMO: Putting It All Together, in response to the comment that I should teach by the book.

When I started my staff managers' training program for post-MBA graduates, it had its ups and downs also. I'd recruit some good people but then we'd have a period where I wouldn't pay any attention to them or to the program (I was busy) and it would sort of drift and people would drop out of the program. Finally we got it going after many curriculum and timing changes, but most importantly, it got going after I assigned more resources to the program.

Hughes: I understand it was simply a matter of rotating through the different functions of the company.

Gumbiner: It was a little more than that. It was set up like a rotating internship, and participants just rotated through the different departments with corresponding didactic work. We tried many experiments. In fact, at one time it was a six-month program, at another time it was a one-year program, and then still another time it was an eighteen-month program. Six months was too short and eighteen months was too long so I think we settled on one year.

Then I had a tremendous struggle with people in the various departments to get them to prepare a didactic presentation for these graduates. The attitude of some department heads was that these individuals would sit in a corner for the month they were in their department, that is, in marketing for a month, in finance for a month, which was not acceptable. I also had the students grade the department heads as to the instruction they had received.

Hughes: Oh, I bet they loved that.

Gumbiner: I told them, "Your bonus and salary depend on how well you teach these people. You need to evaluate each student." When I told them this, they started running around trying to get evaluation sheets. They said they had never heard of them. At the end of the training period, I also had each student write a paper on a given subject before they could leave the program. It was always amazing to me to find what people would write about. You can always see how people celebrate when they write a paper. When I was teaching I'd present a new case study, a brand new one, each session.

Hughes: An actual one?

Gumbiner: One that I thought up from actual experiences. I taught for four hours on Thursdays from six to ten in the evening, after working all day. I worked for a dollar a year, hired my own teaching assistant, and used the faculty lounge in the evenings.

All this made the rest of the faculty mad at me because I was teaching for a dollar a year and hiring my own teaching assistant.

Hughes: But you liked it, I bet.

Gumbiner: It was all right.

It always amazes me how simple it is to think of a good idea, give it to the right person, add a little direction and definition, and a new concept, function, or program emerges. But without the idea, the stimulus, and assignment of resources, nothing happens.

I would give them a current event as part as that evening's session. I would clip a little story out of the paper and I'd say, "I want you to write me a one-page summary, not over two pages, of the problem that is presented here, and what solutions you would suggest." Most of them couldn't do this. These are people that have just finished their MBAs and they couldn't follow instructions. They would either write five pages, or they'd write half a page, or they could not grasp the problem. They were always too busy trying to figure out what the answer was. I told them over and over again, "There are no solutions to these problems, I just want to teach you how to analyze the problem and come up with a reasonable set of solutions. There is no single solution." But they never understood the concept I was trying to teach them regarding how to approach a problem and how to think. It was very difficult. That was the program and it was pretty simple.

The First Strategic Plan, 1970s

Gumbiner: My concept was always to develop management in depth, which was one of the five principles I developed when we did our first strategic plan many years ago.

Hughes: What decade?

Gumbiner: That must have been back in the early to mid-1970s. It took us about a year to develop the five tenets. We wanted to be a growth company (controlled growth). A lot of companies don't want to grow; they want to stay the same, or try to grow without plan or resources. We wanted an organization that was innovative. Some companies don't want to be innovative; they plan to copy. We wanted a company that presented a quality

image, but we didn't want to be seen as a company that was overly affluent or that wasted people's money. We wanted this image of a nice, clean place that was tastefully set up. We wanted to be economically viable and independent. You might say, well doesn't everybody want to be economically viable? No, they don't. Some not-for-profit organizations want to end up spending their entire grant at the end of the year so they can get another grant. You know about that in academia, right? We wanted to develop our staff in depth, which meant doctors and managers. Anything that didn't fit in with those principles we wouldn't do.

I always tried to run a nonprofit organization like a business. There's got to be some money left at the end of the year or you can't do anything; you can't grow, you can't expand, and you can't try anything new.

Management Training Programs

Gumbiner: Later I developed these management training programs at the University of California at Irvine, for which we pay them. I think we're paying about \$80,000 for a doctor/management program in the graduate school of management. FHP is team teaching with the faculty there. They have a professor that teaches a course in marketing, finance, or whatever it is, and we have one of our senior managers teaching the same course. The students get two views this way; they get not only the academic view but also the practical view. This is a certified program and the enrollees get their certificates from the university at the end of the session, and they even have a graduation ceremony.

Hughes: How are the FHP people selected?

Gumbiner: For example, I am asked to give a course in business philosophy, or something like that. The chief executive officer gives one in general management, the marketing vice president gives the course in marketing. We select them for their ability to speak and their knowledge, and we decide the subject matters that they're going to teach. It's part of the program.

We developed a program for those people who already have an MBA, an advanced course for physicians in health care management, and we also developed a basic management program for those people who do not have an MBA.

Hughes: This is within FHP?

Gumbiner: Within FHP. These three programs coordinate with the university's school of management. We have a big training program within FHP, FHP college. We train them in every department. For instance, we have a mock-up of a receptionist's booth and train in that area.

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Gumbiner: In the last few years we've hired a person to head up and coordinate the FHP training program, a person who's been in academia.

We have other training programs for physicians, such as how to talk to patients. We have a special training program where physicians get television feedback on how they approach patients and so forth.

Hughes: These programs are mandatory?

Gumbiner: I frankly don't know if they are still mandatory. If it was up to me they would be mandatory. I was told they were mandatory, but you know how things are: sometimes orders never get implemented, through bureaucratic resistance.

Turning Points in FHP History

[Interview 6: February 20, 1992] ##

Hughes: Dr. Gumbiner, please tell me what you consider to be the turning points in FHP history.

Gumbiner: I think the first major turning point was probably in 1966 when the organization changed from a partially fee-for-service and a partially prepaid organization to 100 percent prepayment. We disbanded the partnership, which was inoperable like most general partnerships, because decision-making was impeded and there was no leadership. At that time, we turned into a traditional corporate structure with leadership and management, with a chief executive and a chief operating officer. That was the first turning point--restructuring the organization to a corporate entity.

The next turning point was when we obtained a prepaid contract for Medi-Cal/Medicaid in the state of California, which was in 1969. This gave us the volume to spread the risk and be able to grow. My original concept has always been that the

federal and state government, or political subdivisions, should be the major driving force for an HMO because that's where the largest groups are, and they can only get bigger. After we obtained the Medi-Cal contract we were able to expand with a fairly secure source of revenue. We moved forward.

Probably another turning point was developing our training programs to give us more management in depth [1971].

The next turning point was the expansion into Guam [1973] and Utah [1976], which gave us more diversification.

Then another turning point for FHP was when we developed our insurance product [1973].

I think moving into matrix management was a significant change. It allowed us to develop our management people [1982].

The next turning point was obtaining a risk contract from Medicare [1983] and enrolling our Medicare population. Each Medicare recipient that is enrolled is counted as the equivalent of four people under sixty-five--the equivalent in the amount of care each uses and the equivalent in the payment that you get for each. If someone has 100,000 Medicare patients, it's pretty much like having 400,000 people under sixty-five as commercial members.

When we developed our IPA was also another high point [1984].

Hughes: What about going from nonprofit to for-profit in 1985?

Gumbiner: That was another turning point.

Another one was when we became hospital-based [1985]. That created a whole new set of challenges, to run a hospital in a more effective manner.

More on the Matrix Management System

Considering the Various Management Systems

Hughes: The matrix system--please start with where the concept originated.

Gumbiner: In 1982 I was thinking about how to manage a widely diversified organization that was very sophisticated inasmuch as we were dealing with a large group of knowledge workers, and one that was diversified geographically as well as productwise. One problem was how to staff for growth. In a growing organization it probably takes several times the staff since new projects take much more staff than familiar projects do. They cost more money and they take more time.

Thus, if you had a one-million-dollar annual gross revenue company, and you wanted to be a two-million-dollar company, you would have to staff for the two-million-dollar company while you were still the one-million-dollar company. Otherwise, you would never get there. The people that are already managing a certain size company are working as hard as they can work and, with a few exceptions, they don't have the time to apply to expansion or new products.

The difference between planning and implementing is applying resources. There are many people who make plans that never materialize because they don't apply the resources to them. The plan is only a dream because they don't apply the money, the time, the energy, and the people to get from the plan to reality. So, the difference between planning and reality is applying resources.

The point was that I had to develop a system that would control this diversified organization, develop manpower for the future, and produce the proper central control and decentralization initiative. I thought and thought about that, figuring there had to be a way. The first thing I did was to do some library research on different types of management organizations. I looked at the vertically integrated central organization that is fairly traditional, where you have senior executives and they have subordinates who run up and down the line carrying out orders. I looked at the decentralized type of organization where each part of the organization operates more or less independently. I finally realized that neither of those ideas was really appropriate.

About that time I came across various articles that discussed the problems of a sophisticated organization that didn't have just salesmen or workers; they also had knowledge workers, such as in a university, a medical group, or aeronautical operation. In managing knowledge workers you can't just tell them to get out there and do it--ask them to all sing the company song and do the work--because they all want to argue about it or they want to know why they should do it a particular way.

Hughes: What do you mean by knowledge worker?

Gumbiner: Somebody that has a particular job because of the specialized knowledge he has and who usually has a professional degree. A college professor, a doctor, a lawyer, an engineer does a particular type of work because of a particular knowledge or level of education he has.

If your company is geographically diversified, you have another problem because you have a communication problem, and if you have a lot of different products, you have another problem.

The only thing I found that seemed to fit what I was looking for was a type of matrix management. This system was developed by the aerospace industry for managing complicated projects. Fundamentally, it was a system where they had corporate and regional equivalents.

Applying the Matrix System at FHP

Gumbiner: The way I developed the matrix system was to have a regional manager who would be responsible for the day-to-day operations of that region, and then have a corporate person who would be responsible for various functions, such as marketing, finance, operations, medical care, and so forth. The key to matrix is that both the functional manager and the regional manager are equally responsible for the people in that region. For instance, a marketing manager would report both to the regional manager and the functional director of marketing. Thus, he would be reporting to the vice president of the region and the vice president of marketing.

The matrix has several advantages. First, if the regional vice president misses something, then the functional vice president in that particular category theoretically picks it up. If a person can't get along with one manager, then he can get along with the other. If he doesn't get enough help from one, he gets help from another.

It was a little chaotic at times since a lot of people could not work in that kind of a situation inasmuch as they felt their authority was being threatened and they were not mature and secure in their own ability. In a way, it tended to separate out the real leaders from the run-of-the-mill individuals. It gives you backup all the way along; nothing falls through the cracks in this system.

Hughes: Didn't it slow the decision-making process?

Gumbiner: Not really, because both people are responsible for the decision, and if they can't agree, then they can kick it up to the person they report to. On the other hand, you can't negotiate or deal too much since we'd figure that they weren't very effective. Most important, no one manager can hide problem areas and impending disaster, and that is the most threatening to the inadequate.

Hughes: What are the disadvantages?

Gumbiner: The disadvantage is that it is a bit chaotic because some of the people couldn't figure out reporting to two different people and had a hard time dealing with that. The more emotionally secure and competent people work better in a matrix than people who are not.

Hughes: How did people like the matrix system?

Gumbiner: Some of them liked it, some of them hated it, but the company did well under that system. You wouldn't have things getting lost, hidden, misrepresented, or lied about since there were a lot more people watching company operations. It was a little more expensive, however.

Hughes: You had more people doing essentially the same thing.

Gumbiner: No, they were watching and approaching things from different angles, the ultimate backup. Theoretically, the functional people were responsible for specialty training and special skills, and the regional people, who obviously couldn't be specialists in everything, would make sure that people were on the job and did what was expected.

We've been using a type of matrix for years in our medical centers. For instance, the center manager was responsible for making sure that people showed up for work or that a lab technician was on time, treated people right, and was pleasant, efficient, and so forth. But the center manager didn't know how to supervise the lab technician, the x-ray technician, or the doctors and nurses. The head lab technician would be responsible for getting good lab technicians and making sure they did the tests right. So, we've really been using the matrix system for years; we just didn't call it that.

I had some people at the School of Management, University of California, Irvine, do a library research project on matrix management. I had taken a couple of seminars on it, so I just

applied the research and my own knowledge to our situation. A big bank, like Bank of America, would have a South American vice president, a European vice president, a North American vice president, and so forth, each of whom would be responsible for operations in those countries. Then they would have a corporate vice president of loans, a corporate vice president of operations, and so forth. Some companies even developed a cube matrix where they might have a vice president in charge of IBM, a lending officer in Europe, and the lending officer in charge of long-term loans. There would be three people in on the decision. I think this is a much safer way of doing business.

Hughes: But you never used the cube matrix?

Gumbiner: I used the cube. I think the matrix system in general is a safer way than hoping the regional vice president is going to be able to manage everything.

Hughes: Was there an attrition of personnel that couldn't adapt to this system?

Gumbiner: There was some. There were some who pretended to adapt to it, some people that adapted to it poorly, some people that fought it, some people that tried to subvert it, and some people that worked very well in it.

Hughes: I understand that as of a year ago, FHP is no longer using the matrix system.

Gumbiner: As soon as I left everybody wanted to do their own thing. It wasn't broken, but they wanted to fix it.

Hughes: So what system are they using now?

Gumbiner: Who knows? It appears to be some sort of decentralized system.

Hughes: You're supposed to know as chairman of the board. [laughter]

Gumbiner: I'm not an operating officer. Another story is how the chairman of the board should act. Whether he should just run the board meetings or if he should actually get in there and supervise the chief executive officer.

Hughes: What is your philosophy?

Gumbiner: Let me think about it. It is an evaluation type of thing. I think the main responsibility is to make sure the company has the right chief executive officer and then sit back and let him

run the thing. If it doesn't have the right man, get rid of him. Of course, there's no easy answer to that evaluation.

Hughes: What have you been doing thus far?

Gumbiner: I've been sitting back and watching it, trying to give management advice without interfering.

Hughes: Would you want to get reinvolved?

Gumbiner: No, that's why I got out of it.

Several studies have been done that indicate that there are several types of chief executive officers. There is the type that stays in until he's carried out or dies. There is the type that is forced out and tries to keep getting back in all the time. There is the type that sticks around and acts as a consultant and stays on the board. There is the type that when they're out they put everything behind them and do something else. And then there is a combination of all these various types. I think some of it depends upon the environment.

That's the story of matrix management. All I know about it is that when the matrix was in, the company was showing good earnings and morale was pretty good. Now that it's out, the earnings haven't been doing very well, and morale is not that good. However, the environment may be different.

Hughes: Why would the matrix system be a morale booster?

Gumbiner: Because it kept everything livened up.

Hughes: I can imagine that some people wouldn't particularly relish it.

Gumbiner: It is very threatening to the inadequate since there is no place to hide. You don't fall asleep because you've got two people looking over your shoulder and two people responsible for every decision. It keeps things lively. Frankly, you have to have fun in management and business or you might as well quit.

Hughes: Have you?

Gumbiner: No, that was not the implication of what I was saying. I said you always have fun in business; it's always a challenge. There are some idiots that take the red-eye when they travel and then turn around and come home on the red-eye. That's not the way to have fun in business.

Dr. Gumbiner's Management Style

Hughes: I want to talk about your management style.

Gumbiner: Well, I listen to what everybody has to say. I elicit opinions from various people. When I've heard enough, I sort it out and get rid of the things that I don't think are appropriate. Then I make a decision. Once the decision is made, we go with it; I don't procrastinate or vacillate. I do listen to a lot of different opinions first, however.

The whole trick is to get adequate information without trying to get too much. Some people are so insecure that they try to get unlimited amounts of information. If they do that, by the time they figure it all out, the opportunity is gone. On the other hand, there are other people who are impulse driven, who get an idea and go ahead with it, without getting much peripheral information. They find out that the idea was a fine idea but maybe in another country or another era, or they determine that it wasn't such a fine idea after all because the information they had was wrong.

The key is to get an adequate amount of information and make a realistic decision based upon that information. That's called judgment. Judgment is an ill-defined skill or characteristic that some people have and some people don't have. I don't really know the psychodynamics of what judgment is, but I'm sure that some industrial psychologist has figured it out.

I would say that my management style is a combination of participatory management and authoritarian management, depending upon the situation. I learned long ago that you can't be totally authoritarian and you can't be totally participatory. You have to use different systems in different situations.

You take a platoon or a squad in the army. If it's in combat, you have to use authoritarian management. In other words, when the squad leader blows the whistle and says, "Everybody get up out of the foxholes and let's go," the soldiers are not going to sit around and debate the order; they go. But the same squad at its rest and recreation camp wants to have a beer party. The wise officer would say, "Fine. Here's the money. You guys plan the beer party."

Hughes: In regard to FHP, when was it appropriate to use an authoritarian or a participatory style?

Gumbiner: You use a participatory style with, say, the doctors to reach a certain decision. You use an authoritarian style to say, "Okay, now that we've all agreed to do that, we're going to do what we agreed upon and anybody that doesn't do it is going to either get out of the way or get out." You have to use some of each, and you have to use them at appropriate times. The thinking of years ago--that one theory of management was good and the other bad--is incorrect because different leadership styles work for different situations and for different groups of people. While different technique attract different individuals, we all know the style that doesn't work--the indecisive, vacillating, timid, no-vision type.

Now that's not to say that people don't have different types of personalities. Some people are quietly aggressive, some people are loudly aggressive, some are nonaggressive, some people are placating, and so forth. I think the good manager has a mixture of all these things. The good manager can quickly identify the problem, very quickly arrive at a reasonable solution, and then move forward and execute or expedite those actions.

Hughes: How many of these abilities are innate and how many are acquired through experience or education?

Gumbiner: It has to do with the emotional quotient or the individual's own self-esteem, lack of anxiety, self-confidence, and education through experience. A good portion is learned through experience if the person can learn. No one is born with these abilities but then again, some people never learn because of their own personality.

There are many people that are very innovative but they never innovate because they're afraid that if they speak up with an idea, they'll be criticized, chastised, or demeaned. You can see that in town meetings there are people who never speak up. I've gone to political and town meetings and gotten up to say that I didn't like something and didn't have a soul get up to support me. I'd walk out of the meeting afterwards and two or three people would come up to me and say, "That was a good idea. I really believe that." I'd say, "Well, why the hell didn't you stand up and give me some support then?"

I think it's an emotional thing. It's how confident the person is in how smart he is, how quickly he can assimilate information, or how much he is blocking because of various fears and anxieties. Probably the worst thing is people who attempt to outguess their boss. They have a problem and try to figure out how the person they report to would approach or solve that

problem. But since they're not that person, and they have a different personality, they can never outguess him because they seek out and assimilate different facts and have a different interpretation.

My management style is pretty much getting the proper information, making a decision, and then very aggressively proceeding to get it done.

Hughes: How much of FHP's success is due to people other than Robert Gumbiner?

Gumbiner: Well, most of it. You never get anything done unless you get it done through people. Probably my biggest job was building the company by picking the right people. But picking the right people and getting them into the right positions is another thing. Many times you pick the right people for the position they started with and then they get caught by trying to take on more than they have the ability to manage or even want to manage.

Some people have the ability but they don't want to commit as much time and energy to the problem or the job. Other people want to advance to a position of more responsibility, authority, power, money, prestige--or their significant other wants them to do that, which is even worse--and they just don't have the ability, they're just not smart enough, they're not tough enough, they get their feelings hurt, and they want to be loved more than they want to succeed.

I think in true leadership you can't worry about whether somebody likes you or not because people don't like change. Change threatens people and they're not going to love you if you want to change something, or get it done faster than they want to do it, or whatever's going on there. So you hire people who do not need to win popularity contests, but they want to achieve something.

Entrepreneurism

Gumbiner: It's an interesting process because as an entrepreneurial organization gets bigger, you attract more and more people that are looking for security. They are looking for a bigger organization. If they weren't looking for security, they would be looking for a small organization. In the beginning, you get more people who are risk takers, who are more entrepreneurial,

and as you get bigger you attract fewer of those people and it is difficult to keep up the original proactive entrepreneurial attitude.

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Gumbiner: This is a pretty well-known factor and that one is talked about in management circles, particularly by big companies. They keep trying to generate the entrepreneurial spirit within this big company which, of course, is antithetical. It's a disclaimer because the type of people who join a big company are not interested in risk; they're interested in security. I noted in a newspaper article the other day where IBM was trying to set up smaller companies which it would sponsor financially, entrepreneurial companies that would manufacture and produce parts of IBM's package. It will be pretty interesting to see if it works.

The big insurance companies have very a difficult time taking over the HMOs because the HMOs are full of entrepreneurial risk-takers (at least the people who started it are), and the insurance company is full of a bunch of people who are security oriented. That's why they joined the big insurance companies in the first place. The whole notion of the HMO is to take risks; they're at risk, period. The insurance companies, on the other hand, are developed to avoid risk at all costs. That's why insurance companies have actuaries that sit around with moss growing on the north side and try to tell others they can't do anything. They are essentially historians, and with the fast-moving developments in the medical field, history may not be enough. The accountants, the actuaries, the attorneys, and the people working in human resources are all geared to tell you what you can't do and not what you can do. If you listen to them you'll never do anything. That's the main problem, and it will be sort of interesting to see what happens as the bigger, more established companies buy up and wipe out the little companies.

Hughes: Well, in many people's eyes you are the entrepreneur par excellence. Did you realize that style had to change as the company grew?

Gumbiner: Yes, I realized that. That's why I developed the matrix, and why I developed the management team and the progressively changing organizational structure, and why I left. As the company got bigger, it got boring. You can't easily get things done because of the bureaucratic blocking that occurs. The whole thing is, you have to motivate people. If you give someone an order, it will never get done unless you motivate him

to get it done because he'll find a thousand different reasons not to do it if he is not motivated. The more attorneys and actuaries you get, the less you can get anything done. When I started the prepayment field, I was assured by almost every financial person, actuary, or attorney, that one, it was illegal, and two, I would go bankrupt shortly. When I took on the Medi-Cal program, I was assured by the same erudite group that it was an impossible situation and that we would soon go broke.

Hughes: Did that give you pause?

Gumbiner: No, I never thought about it. My nine partners who had left assured me that I would go broke too. I guess the true entrepreneur is the person who never thinks that something will fail, and if it does fail, he just thinks that he didn't try the right method--it's not a failure. Now you can get trapped by that and beat your head against the wall forever. The key is to figure out when something is really not workable, or when the effort or length of time is too extreme for the benefits.

Hughes: Did you have trouble pulling back when you saw something wasn't right?

Gumbiner: Oh yes, I had a lot of difficulty. Our board finally said I had to deactivate the insurance company since we were pouring money down a rat hole. I listened to them and said, "Yes, that sounds reasonable to me; we'll deactivate the insurance company."

Hughes: I bet it wasn't always that easy.

Gumbiner: You chew on it for a while, think about it, and then make a decision. There are people all the time that look at something, and if they can't figure it out, they'll just pour money, time, and energy into some project that's not worth it. If you can't make any money at something, you might as well not do it because you're not going to be able to pay your personnel. The worst company you can run is a bankrupt one; no one has a job and you can't deliver health care to anyone.

That was the problem with the nonprofit HMOs. In general, they were not organized to make money; they were organized to deliver health care. The problem was that after they took in the revenue and paid their expenses, there had to be something left to develop the company, but they never did realize that.

Kaiser Permanente

Hughes: Well, Kaiser is nonprofit.

Gumbiner: I wouldn't say that. The Permanente Medical Groups are certainly not nonprofit.

Hughes: Well, that's true.

Gumbiner: Their pharmacy organization is certainly not nonprofit. The only thing that's nonprofit about Kaiser is the hospital foundation which, in a way, is organized to make sure that Permanente Medical Groups are for-profit. In fact, they got sued not long ago, and the claim was that the for-profit pharmacy operation was feeding the not-for-profit medical group. Fundamentally, the only difference between not-for-profit and for-profit is that in the for-profit company someone gets a dividend or a monetary return for his investment risk. In not-for-profit companies, people don't get a cash return for investing their money, time, or energy. I guess the difference actually is in investment return, whether you're investing in cash or you're investing in time and energy.

Both types of organizations could be run pretty similarly by people who are achievement oriented and want to do something. Of course, the nonprofit doesn't pay any tax, which the for-profit does. Anyway, what else did you want to discuss?

Hughes: Did and does FHP treat its physicians as employees?

Gumbiner: Yes, the staff physicians are employees.

Hughes: How does that work?

Gumbiner: It works fine; it's the only way to work.

Hughes: Why do you say that?

Gumbiner: Because partnerships are dysfunctional and are organized to fail. You can't have leadership if everybody is a general partner. Also, individual fee-for-service group practice is dysfunctional.

Hughes: Kaiser still has some partnerships.

Gumbiner: Are you kidding? That's not a partnership.

Hughes: There are partnerships, depending on the region.

Gumbiner: Of course, they've got professional corporations, partnerships, and other formats, but even their partnerships are not partnerships in the sense of control.

Hughes: Why do you say that?

Gumbiner: I'm going to tell you why. Here are some anecdotes. Kaiser acquired the San Diego Health Plan back in the fifties. This health plan was one of the early nonprofit HMOs and there were about thirty doctors with them at that time. (I know that because I tried to acquire it and didn't have enough money.) If I recall correctly, it was the partnership in Kaiser south that was going to staff it. The partnership in Kaiser south said, "No, we're not going to staff it because it might cut into our income." So the Kaiser Health Plan said, "Fine, then we'll have Kaiser north staff it." When they were threatened with this, Kaiser south turned around and staffed the plan.

I'll give you another example. Kaiser's Oregon region was on the rocks; Kaiser was having trouble with the medical group in Oregon.¹ All of a sudden they got a new medical director, and where did the new medical director come from? Kaiser of San Diego, that's where. Now how was he elected by the doctors in Oregon? Think about it.

Kaiser also has an informal group of the regional managers and the regional medical directors that meet--I don't know if it's quarterly or how often. In my view, the Permanente Medical Groups are a partnership in name only, and they take their direction from Oakland headquarters. They are really a sort of a profit-sharing plan.

The partners really don't have a whole lot of voice and say-so in the overall strategic planning because they only have one master, they only negotiate with one health plan (HMO) and that's Kaiser Health Plan, which gives them all their revenue. They don't get revenue from anybody else, so in my view they are a type of profit-sharing program. After you've worked there for two years you get some kind of a share, which entitles you to a share of profit. I'm not too sure if the doctors fully understand how that's developed. Even if they did understand it, they couldn't prove the numbers. They just take whatever is handed to them as a given and get whatever share somebody has decided they should have. See, that's the key to Kaiser

¹For more on Kaiser Permanente's Oregon region, see the forthcoming oral history with Scott Fleming in the series, History of the Kaiser Permanente Medical Care Program.

Permanente: they're not a democracy and they're not a partnership, and Oakland runs the operation because it has all the organization and money.

Hughes: The doctors do have their own board, the PMG Executive Committee.

Gumbiner: Oh sure. They can rattle around and make all the decisions they want, but following the golden rule, that is, he who has the gold makes the rules. [laughter]

Physicians as Employees

Hughes: Did you have trouble over the years because FHP considers physicians employees, which isn't the way the American physician usually likes to look upon himself?

Gumbiner: The American physician is going to be mostly an employee from now on.

Hughes: Well, I know that, but what about in the past where that certainly was not the case?

Gumbiner: As I said, I created a model, and part of that model was that the physicians would be employees if they joined our organization. I drew a line in the sand and decided there could be no ifs, ands, or buts. I told them, "If you object to being an employee, you're not going to join us." It was very simple. College professors are employees, medical school staff are employees, researchers are employees, military doctors are employees, VA [Veterans Administration] doctors are employees, and so on. I don't know where you get these ideas. Maybe you talk with too many country club doctors.

Hughes: But sometimes it's not really as simple as that.

Gumbiner: I'm a simplistic thinker. [laughter]

Hughes: An individual might think, "Well, I'll change the system."

Gumbiner: And I'd let them know right up front that they weren't going to change it.

Hughes: And you were very willing to let physicians go?

Gumbiner: Of course. I don't need troublemakers.

Hughes: It's an expensive procedure to hire and fire physicians.

Gumbiner: It's more expensive to hire the wrong ones. You're better off spending the money up front to recruit the right people. See, some physicians are simply, subconsciously, authority resistive. It's a strange phenomenon: in medical school they are totally subordinated to the faculty who can kick them out, just give them a bad grade and they're gone. Then they become an intern, they are totally subordinated to everybody else, the residents, the teaching staff, and so forth. Then when they become a first-year resident they are down at the bottom of the pile again. Finally, when they get out of residency and go into practice, boom, they're down at the bottom of the community doctor pile, and all the bulls out there lock horns and stomp all over them.

I think what happens to some of these weird characters is that they think, "I've been forced to be subordinate all these years, so when I get out I'm going to be my own boss." But what they do not understand is that the patient is the boss. If patients are not available, physicians don't have a practice-- they sit and look at the walls and play gin rummy with one another.

Hughes: But that wasn't the case at FHP; there was no dearth of patients. I know you were screening physicians, but I don't believe that any screening system would be totally adequate.

Gumbiner: We are all fairly imperfect. No matter what you did, once they were historically rubbed on the grindstone of reality, you got down to what the real character looked like. No doubt about it, we had a certain amount of physician turnover.

Some of the top people in the Permanente group told me they used to have three out of four doctors quit or be removed during the first two years. They created their own monster because everybody knew them throughout the country. If somebody wanted to move to the West Coast, what would they do? They'd get a job with Kaiser Permanente for a year or two, or until they scoped out the situation and found a place to practice, and then they'd split. We had the advantage that no one had ever heard of us, so we didn't have that big a problem with attracting all the flies to the money.

More on Group Health Association of America

Kaiser Permanente's Role

Gumbiner: I had a lot of trouble with Kaiser Permanente throughout my career, particularly in the trade association [Group Health Association of America] which they tried to dominate.

As I told you, everybody knew there was an elephant in the tent: Kaiser dominated all the committees, the leadership, and was fairly blatant and arrogant about it. It would ram things through the board of directors. I was on the executive committee for probably ten years and we could never get anything done. I was chairman of the membership committee and then of the bylaws committee. I reorganized the bylaws and membership committees.

Kaiser Permanente's motive was very simple. I mentioned that it had three lobbyists in Washington, D.C., and was the only HMO that had lobbyists there until we opened our Washington office in 1977. It was very valuable to Kaiser if the policy of the trade association was identical with its policy on major issues. Therefore, Kaiser made sure that it controlled the trade association so that when Kaiser took a stand on an issue, the trade association was lined up right with it.

For instance, FHP lobbied to remove HMO hospitals from the certificate of need in the late seventies or early eighties. There was a certificate of need for which the applying entity would have to prove that more hospital beds were needed in a particular community before you could build more beds, either a wing in a hospital or a new hospital. At that time I was on the California Health Advisory Committee, which was a state committee that supposedly advised the governor. Actually, it turned out to be the state appeals board for the regional certificate of need boards, so we would get all these appeals. In any event, it just seemed totally illogical to me that the HMOs should be forced to use these inefficient and expensive private and community hospitals, and that they should be governed by the same rules with regard to building hospital beds as the very system they were trying to supplant.

Hughes: Kaiser took an opposing view?

Gumbiner: Yes, Kaiser took the opposing view.

Hughes: Why?

- Gumbiner: I'm not quite sure, except that I think it already had its hospitals built in most of its regions and was more concerned about an extension of the certificate of need concept to building medical centers.
- Hughes: Are you sure about that?
- Gumbiner: Yes, I know that.
- Hughes: But Kaiser was constantly expanding! It expanded to the Midwest and East Coast.
- Gumbiner: It hadn't expanded at that time and those units were not hospital-based. Kaiser wasn't in Washington, D.C., and Georgetown then. I think it had a deal with Senator Kennedy; Kennedy's people were trying to put outpatient facilities under the certificate of need. I don't know whether that was a fear that it would happen or if someone was misinterpreting the law.

We lobbied a bill exempting HMO hospitals from a certificate of need through Congress. Bob Erickson asked me if I would lay off because he had a deal with the Kennedy people that if Kaiser didn't lobby for removing the HMO hospitals from the certificate of need, the Kennedys would not put the pressure on to pull the ambulatory centers under the certificate of need. Phil Graham, who was a Texas professor and a Democrat then (I think he's a Republican now), was a congressman on Henry Waxman's subcommittee [on health and the environment]. He thought it was a good competitive idea that the HMOs be removed from the certificate of need requirement. He became the champion of this and, lo and behold, supported this bill through Congress.

I got a lot of pressure from both Kaiser and the trade association to stop supporting the bill. You asked me why they would do that? I have no idea why they would do that other than the deal they had cut with the Kennedy people. Kaiser has always been difficult.

Kaiser withdrew from the trade association; I pulled our people out about five or six years ago because I decided that we weren't going to pay dues to an organization that didn't represent us--sort of Boston Tea Party.

- Hughes: It didn't represent you because it was speaking the Kaiser line?
- Gumbiner: Yes, it was dominated by Kaiser. It was an amazing situation. There were some 200 to 250 staff models throughout the country at that time, which had no representation in Washington. They

relied solely on the trade association as their legislative advocate and were totally misinformed about the trade association representing their views.

Hughes: They didn't have representation in Washington because they thought the trade association was doing it.

Gumbiner: Right, I'll give you an example.

Redoing the Bylaws

Gumbiner: When I redid the bylaws, I had this interesting little problem. As I told you, I was on the executive committee of the GHAA and had been chairman of the membership committee for a number of years. When I got to be chairman I said, "Wait a minute. There are no standards. How do we know who we're supposed to let into this organization?" We organized a standards committee with a Kaiser representative, John Smillie, head of it.¹ I was on the committee and we met throughout the country at different places to develop standards. The standards were that an HMO applying for membership would have to be a staff model. We had a little bit of a fight about whether it would be not-for-profit or for-profit. (Remember, we were not-for-profit at that time.) But I maintained the position that it didn't make any difference, it was unimportant whether an HMO was for-profit or not-for-profit because it could be just as good or just as bad by being either one. The standards committee remained silent on that point, so I proceeded to keep out any organization which was an IPA and not a staff model, and whether they were nonprofit or for-profit didn't make any difference.

I might say, I helped build up the membership, which wasn't really to Kaiser's liking because the more members in the organization, the more their power might be diluted. After about five years of that, they reappointed the committee. And guess what? They made me chairman of the bylaws committee; they figured that would finish me off.

I read the bylaws and found out that they had been developed in something like 1980 in Minnesota by the farmers' union, or something like that, and were totally inappropriate and out of date. The next thing I heard, somebody called me and

¹Dr. Smillie's oral history is one of the twenty volumes in the Kaiser Permanente Medical Program Oral History Series.

said the trade association had just formed a reorganization committee to reorganize the trade association. He said, "How come they're doing that? Don't you have a bylaws committee?" I called the associate president and said, "What are you doing?" He said, "Well, we've got this reorganization committee." I said, "I thought reorganization was the bylaws committee's problem." He said, "Well, we're going to give you the data after we make the decisions, and you can write the bylaws." That didn't make any sense, so we had a combined reorganization and bylaws committee.

Scott Fleming was chairman at that time so I made sure that the bylaws committee had loose direction from this combined committee. The reorganization committee was disbanded after it set the general policy. After that the Kaiser Permanente group managed to get Scott Fleming elected as the vice chairman of the bylaws committee in order to protect its interests and to influence the bylaws.

Fleming used to get up and say, "I'm an attorney and I know this and that!" I said, "I don't give a damn if you are an attorney." John O'Connell from the East Coast Blue Cross plan was on the committee and was also an attorney. John would jump up and say, "Forget it, Fleming. I'm an attorney too and you're wrong." [laughter]

This whole thing finally came to an interesting showdown. We had devised the bylaws so there was a compromise. The large plans, which at the time were Kaiser Permanente, Group Health Cooperative of Puget Sound, and Health Insurance Plan [HIP] of New York, each got two permanent seats. Then the intermediate-size plans, like ourselves, Group Health Association, Inc., in Washington, D.C., the plan in Minneapolis, and a number of other plans about our size would each have one seat. Any HMO of over half a million members had two permanent seats, and those HMOs of 250,000 to 500,000 had one permanent seat. Then there were about ten or twelve seats left. (I used the model of the United Nations Security Council where the big nations have a veto vote and a permanent seat.)

My position was, and I tried to get this through, that all the rest of the members of the trade association, the smaller plans as well as the developing plans, would each send in two nominees for those seats. All of these nominees would constitute a slate for a vote to select the top twelve for election to the board of directors--very democratic.

The Kaiser people hit the ceiling because there would be twelve votes they couldn't control. I had already made one

modification for them. They claimed there were three Kaiser plans: Kaiser north, which should have two seats, Kaiser south, which should have two seats, and then there were some other Kaiser units. They divided themselves up and ended up with six seats. But that still wasn't enough. Even though they had friends in half a dozen medium-sized plans, there were still ten seats that Kaiser was going to lose control of. Smillie and Fleming did a quick shuffle on me and Smillie proposed some confusing motion that for the good and welfare of the organization, the seated plans would select the twelve plans for the other seats. Well, since they controlled six out of the twelve votes, all they needed was HIP and Puget Sound to vote with them and they would control the whole organization. The organization voted their undemocratic proposal through. To tell you the truth, the board of directors was sort of a strange and stacked group.

I would sit through these meetings for two and three hours in which the trade association would present its position on legislation. We had set it up in the bylaws that the legislative committee would examine the legislation, listen to all the various analyses, and would then make position recommendations to the executive committee of the board of directors.

Kaiser didn't like that and raised all kinds of hell about it. It didn't want the committee to make recommendations; it wanted legislative positions to go to its controlled board. It also wanted to be able to take a straw vote, or something like that. I said, "What are you talking about? If you've got a legislative committee, it is supposed to do the work, that is, examine the options and make recommendations." Then Kaiser came up with this canned presentation of the trade association's position on various pieces of legislation--it had nothing to do with what anybody ever wanted. At that point I made it my business to find out what other trade associations did. In general, they would poll their membership or find out in general what the membership wanted, but that didn't happen in GHAA.

In any event, we would end up with twenty-five or thirty people, the board of directors, sitting in a room for two or three hours listening to one presentation after another, and voting yes, yes, yes. Then they would file out. It was unbelievable to me. All these people were CEOs of various health plans and we sat there like a bunch of neuters. Every once in a while one of the union guys would jump up say, "What is this? Aren't we supposed to discuss things?"

Finally I just pulled FHP out of GHAA as I couldn't stand it any longer. It was an interesting experience, however. I learned how to drive things through and manipulate the masters.

Hughes: Learned? I think you'd already learned that.

Gumbiner: No, I learned that from those guys.

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Gumbiner: Just before I pulled our organization out, we had a meeting. Scott Fleming took one position and I took another, and the entire bylaws committee voted with me and against Fleming. The next day we had a board meeting. Fleming lobbied hard the day before the meeting and got some guy who had been on my committee but had not been to any meetings to get up and say, "If I had been at the meeting I would have voted this way." I said, "What are you talking about? You never heard the pros and cons." Fleming also had another guy get up and say, "I move that we strike the report of the bylaws committee from the record." He had it fixed for somebody to second the motion and he ran it through. Some guy even got up and said, "I can't understand this. What are you doing?" I said, "I quit," and left.

Now they really have come full circle. I understand now the big insurance companies are taking over the trade association and Kaiser is starting to have meetings on the side with other HMOs trying to figure out how they can get the trade association back. As a matter of fact, I understand that Aetna, or some other insurance company, has the chairmanship this year. It's going to be pretty interesting to see what happens.

Hughes: Has FHP suffered by not being a member?

Gumbiner: Not at all. They never lined up with us anyhow. What do we need them for? It was taxation without representation.

Hughes: The dues are considerable, aren't they?

Gumbiner: Yes, they cost about \$80,000 a year (so much per head). I was the first one to say, "What are you guys doing? You're living off the soft money." GHAA was operating off the grants. I said, "Get your dues up in order to pay your overhead, and then if you get some grant money you can do some interesting things on the side." They were living from one grant to another, but I was able to get that changed.

After I left the board of directors they changed the bylaws to get rid of all dissidents, including us. I think my people

have joined the trade association again on a six-month trial basis. FHP said, "Either give us a board seat or we're not going to continue." I'm going to the policy meeting next week to see what's going on.

The Senior Health Plan

Medicare

Hughes: Describe the Senior Health Plan, please.

Gumbiner: I lobbied for Medicare back in '65 and '66 when there were only a few doctors lobbying for Medicare. I always felt that there never could be any insurance company that could get the spread of risk to cover the senior population since seniors use four times the care. The longer you keep people alive, the more illness and disability they are subject to and the more expensive they become. The only people that readily pay premiums and join plans are those people that are sick and are going to use the plan. Why would you buy something if you're not going to use it? I was a great proponent of spreading the risk over the entire population whether you're well or sick, period, and that means compulsory enrollment. This concept was a learning process for the Medicare people.

In the beginning there was part A (hospital coverage), which was automatic, and then you had to join part B (doctors' coverage). In other words, you had to indicate that you wanted part B. They tried everything to get enough people to sign up for part B--they went door to door and had a cartoon campaign--but only the sick people signed up. Then they got really smart and changed the regulations so everyone was covered by part B. Under the new regulation part B was deducted from your Social Security check unless you wrote the secretary of HEW [Health, Education and Welfare] and told him you didn't want part B. This was a total 180-degree policy change from what it had been.

I will say that the trade association lobbied the risk contract through. I think Kaiser liked it because it had a certain group of seniors as members. It had been around long enough that it had a large group of members that were turning sixty-five.

In the early days of Medicare I'd been in on developing, with a number of other people, the so-called cost contract

through Social Security. It covered the cost of providing the doctors' portion of part B, the ambulatory care portion, but it didn't cover the hospital portion. The hospital still billed fee-for-service.

The risk contract was pretty simple to me. I took a look at our data and, as I remember, it was costing us about twelve or fifteen dollars a month per person for hospital care for the over-sixty-five population. Then for non-Medicare hospitalization on a capitation basis, it was so much per head. I easily figured out what was being paid for part B under the cost capitation agreement of Social Security and came up with a figure of over \$100 for part A. If we gave the seniors four times the care, it should be four times twelve, or \$48 to \$50. I came to the conclusion that there was a \$50 difference in the hospital portion for risk.

The people at Kaiser figured that out too. All it was getting paid for was fee-for-service on the hospital portion. If it went to capitation in the hospital it would have fifty dollars a person for many thousands of people. We'd been on a cost contract for doctors' ambulatory care for years and we could just about make ends meet. That didn't make any sense because there was no return on our investment (nothing for risk) so we couldn't develop any additional profit in order to build new buildings, hire new doctors, or try new things. It was just antithetical to what we were trying to do, plus it was just not good business practice.

I said, "Well, this risk contract is great because we can take that other fifty dollars a head and for that we can remove the deductibles and the copayments, adding preventive care and prescription drugs." The question was, what would the Health Care Financing Administration do? HCFA is the financing arm and does all the experimental work for the Department of Health and Human Services. HCFA set the rate by paying the risk contractors 95 percent of some strange mathematical formula it was paying in the country.

There were a lot of terrible defects in this system. One was what HCFA called the Average Adjusted Per Capita Cost where it was taking a historical average of the last three years. Of course that didn't reflect what it was going to pay the coming year. If health care costs went up 10 percent, that would be an average of 5 percent during the year. And if they went up 20 percent, they'd be going up an average of 10 percent and that wouldn't be the average of the last three years. There was a big outcry when this happened. We thought we were being paid about 80 to 85 percent, even if there was an estimated cost

increase added, since we are taking the average of the last three years.

Then they alleged that they had plugged in the inflation factor. Well, I think last year they plugged in an inflation factor which they thought would be the result of the changes in the payment system for 1992. For instance, the new regulations called for paying the general practitioners and the primary care doctors more than they paid the specialists. Therefore, they were going to lower the costs. That would not work because the specialists would not allow their income to decline. They would be getting paid less for a procedure. So what are they going to do?

Hughes: More procedures?

Gumbiner: The average surgeon can make a really decent living by doing two or three majors operations a week, which only keeps him occupied for one or two days a week. Thus, he can increase volume whether it is needed or not. So that's not going to work. I think they projected a lower inflation rate for next year, and that is the rate they tried to pay us.

The deal was, Medicare paid 95 percent of what the average payment was in that county. We were a little naive because we hadn't figured out how they determined the average payment. I knew that under prepayment we could provide the same care for less, but not 5 percent less. Maybe 15 or 20 percent less, if you figure the extra marketing and administrative costs, but not 5.

Increasing Plan Benefits

Gumbiner: There was another 10 to 15 percent of revenue to increase the benefits, which we did. We used it to remove the copayment of the 20 percent allowed for doctors' care and the \$500 deductible for hospital care. Using those same savings, we added prescription drugs, some psychiatric care, and preventive care, such as immunizations for flu and health education.

I knew that there were four to six pilot projects involving risk capitation contracts preceding our program. I reviewed all of these pilot projects, including visiting with the people. John O'Connell, who was another attorney on my bylaws committee at GHAA, was head of Fallon Group Health Plan in Massachusetts. He had put together a pilot project for Fallon, and he was one

of the people I visited. This plan was a Blue Cross spin-off so they really didn't have to spend that much on marketing since it was a converted Blue Cross plan.

After I looked at all these plans and had figured out which ones were successful and which weren't, and why, I realized I really didn't know how to start a program like this. I contacted John, whom I had gotten to know very well through the many committee meetings we'd attended when we wrote the bylaws for GHAA, and I ended up bringing John into our organization. He was getting a little tired of Massachusetts in the winter anyhow. He set up our Medicare program and moved it through the federal bureaucracy. That was the beginning of FHP's Medicare program.

The Senior Health Plan Center, Long Beach

Gumbiner: Then I conceived another idea. I thought to myself, "The most efficient and effective way to take care of seniors is to create a senior center where WE could provide certain things that you wouldn't provide in another center." Some things were as simplistic as larger signs that older people could read, better PA systems so they could hear their names being called, and a system where they didn't have to move as fast, where we could set up seats outside the examining room. The center would have a much bigger pharmacy because seniors use six times the pharmaceuticals. We had a pharmacist interview each senior as he enrolled in the plan to find out what his drug history was and put it on the computer so we could eliminate overmedication, duplicate drugs, and so forth. We also set up a coffee center at each of the senior facilities.

We finally got the Medicare contract, which was supposed to start at a certain time. Then the feds told us that we had to have a facility up by the time the contract started. I didn't think I needed to do that because people are not going to come in the first day they're enrolled. However, the deal was we had to be up, equipped, and ready to go in ninety days. Fortunately, we had a skating rink we could set up in time. I had just put a new roof on this building since I had been thinking of making it into a health club. We had to totally renovate this building in ninety days, plus equip it. We worked on that building twenty-four hours a day, seven days a week. We even had someone on stilts putting up the wallboard and painting it so he didn't have to move ladders around. [laughter]

The building had this beautiful maple hardwood floor, 20,000 square feet of it, three quarters of an inch thick. You don't get three-quarter-inch maple hardwood anymore. One day I noticed there were burn spots on the floor in the hall. I finally figured out that the burn marks were from a string of light bulbs these guys were using when they had to work around the clock. They would string these light bulbs throughout the building and then once in a while some stupid guy would lay the light bulb on the floor, which accounted for the burn spots every six feet and necessitated having the floor sanded.

I had allocated \$1 million to the Medicare program advertising and marketing campaign. We marketed to probably 10,000 people in six to eight weeks, which is one of the keys to success, as I said before.

There are four keys to success in the Medicare risk field: enrolling enough people, at least 10,000, to spread the risk; spending enough money on multi-media marketing; charging no premiums--we didn't charge any premiums because we were supplying extra benefits out of that savings from the hospital money; and providing prescription drug coverage to keep people from getting too sick and needing hospital care.

Anyway, the senior plan was very successful. There were about 45,000 seniors in downtown Long Beach at that time and we enrolled 10,000. Subsequently, there were some interesting changes. In 1983, the seniors that joined us in their late sixties were now in their late seventies, and seniors who joined us in their seventies were now in their eighties. The enrolled seniors got older, they now had more problems, and the costs had gone up. Plus the fact, during that period of time Long Beach went through a redevelopment program and destroyed the apartment buildings that the older folks were living in, and so we've had an actual decrease in the senior population there.

Hughes: Has that put the senior plan into jeopardy?

Gumbiner: No, it's just a little more difficult. I think we probably have 8,000 members there now instead of 10,000.

The whole challenge is to enroll people who age in so that you have an equal spread among the younger seniors and the older seniors. I don't know if they've done research to find out whether all the plans for seniors are costing more.

The fee-for-service sector got very excited when they saw how successful we were with all the additional benefits at no premium. It was a real threat to their exploitation of the

system. They claimed we were only enrolling the well seniors, which of course was not true. We enrolled the whole spectrum, the well and the sick. As a matter of fact, I think I concur with what the people told me at Puget Sound, that the community doctors had dumped the sick people on the HMO prepaid senior plan. If they found somebody who needed cardiac surgery, they said, "Well you can't afford the 20 percent copayment for the \$25,000 the surgery will cost, so why don't you go to FHP and present yourself, join their plan, and then have them do the cardiac surgery?" This was the same for renal surgery, or dialysis, or cancer surgery, or you name it.

Initially we formed three senior plans (senior centers), one in Anaheim, one in Huntington Beach, and the original one in downtown Long Beach. Subsequently we formed senior plans among the IPAs where the doctor just melded in the seniors. I don't think that's a wonderful idea because most seniors don't want a bunch of kids screaming while they're in the waiting room, plus they move at a slower pace.

Expansion to Arizona and New Mexico, 1985

Hughes: Well, do you want to move on to the expansion into Arizona and New Mexico?

Gumbiner: Expansion to Arizona and New Mexico is not a very thrilling story, to tell you the truth.

Hughes: Why do you say that?

Gumbiner: Because the expansion was to IPAs, it didn't have any of the pathos and chaos of the other extensions. Why did I do it? We decided we wanted to diversify out of California because who knew what was going to happen? The California state government might decide to put in some kind of plan that would totally wipe out our HMO, or make it difficult to operate.

Hughes: And Guam and Utah weren't enough?

Gumbiner: If you don't grow at least as fast as the environment, you go backwards. So I said, "Where shall we go?" At that time we thought we needed a community of at least 500,000 people. (I now think a successful HMO needs a community of 1,000,000.) We wanted a place that was growing, and one that had no other HMO competition or had weak competition. We also didn't want to extend further than one time zone away, that is, we didn't want

to go beyond the Rocky Mountains. So, we looked at all the cities in the West over 500,000.

Hughes: You didn't want to go beyond the Rocky Mountains because of management problems?

Gumbiner: Geographic expansion beyond a certain point causes excessive management problems. You can't even call people up at the same time, plus management is reluctant to make long time-consuming trips on a frequent basis. We looked at [Group Health Cooperative of] Puget Sound in Seattle, which was totally entrenched there, and at Kaiser in Portland and San Diego. Some of the Western states--Wyoming, Montana, Idaho--weren't big enough and didn't have any cities of over 500,000.

We found two cities of over 500,000 that had weak HMO competition, Albuquerque, New Mexico, and Phoenix, Arizona. Albuquerque had Loveless Health Plan, which had been in and out of the prepaid system for fifteen or twenty years and couldn't make up its mind. Whatever doctor happened to get control of the partnership would steer it one way or another. One time they closed all their prepayment, then started it up again, and then closed it down again. They even had their federal employees' contract cancelled. I decided Albuquerque would be a good place to go because the people running Loveless didn't know what they were doing.

Loveless was very aggressive with a new competitive program of putting "Docs in the Boxes" to provide urgent care and family practice all around Albuquerque. It eventually set up twelve of these centers there, which were used as walk-in clinics for its prepayment plan, and eventually it put in a big specialty center on the north end of Albuquerque. The specialty center was very costly to build and once completed they became very frightened that they would not be able to bring in the additional membership required to support their facility expansion.

In Phoenix there was the Arizona Health Plan that had been very aggressive under Don Schaller, but was eventually purchased by Cigna. It started as a joint project between Connecticut General Insurance Company and a medical group in Phoenix. Cigna was created by the merging of Connecticut General Insurance Company and INA Insurance Company, and Cigna took over the Arizona Health Plan. Needless to say, the insurance company didn't know how to run an HMO, but in its arrogance it thought it did. It staggered around with large losses and no one knew if it was going to stay in the HMO business. Cigna woke up with a start and madly started to expand and put in more centers. So, we thought we were going into a market we could easily

penetrate. However, this area became a highly competitive market eventually.

While we were thinking about this, three or four other groups were thinking about it also and moved a little faster than we did, but more erratically since we wanted to do it in a more organized fashion. Sierra Health Plan and Foundation Health Plan went into New Mexico and both folded without adequate research, management, or money, and then folded their tents and slunk away. FHP ended up with Loveless and an HMO formed by the Presbyterian Hospital, which were the major players.

In Phoenix there was a local plan that was an extension of Tucson Medical Intergroup. So we were in Phoenix, Tucson Medical Intergroup was there, Cigna was there, and then a couple of other minor players were there. We're doing very well in Arizona, we're doing fair in New Mexico, and that's the end of that story.

FHP as a Model for U.S. Health Care

- Hughes: Are you playing a direct role in planning the future course of health care in this country?
- Gumbiner: Yes, I've written several position papers on remodeling the U.S. health care system.¹ At the request of various individuals in Washington, D.C., I sent off my latest two papers.
- Hughes: To whom?
- Gumbiner: Senator Bill Bradley wanted one, Senator George Mitchell, Senator Tom Harkin, Congressman Richard Gephardt, and Ron Brown of the National Democratic Committee, plus various other people. I haven't heard anything from them but anticipate that I will.
- Hughes: Do you look upon the FHP model as useful on a large scale in this country?

¹The most recent policy statements that Dr. Gumbiner has distributed throughout Washington, D.C., are: "Policy Statement RE: National Health Care System," February, 1993; "Basic Principles - \$750 Billion Annual Cost of Health Care," February, 1993; and "Policy Statement RE: Mental Health and Long Term Care," May, 1993.

Gumbiner: Yes, I still think that the staff model is the most efficient model and that the IPA model, without a staff model component, will eventually self-destruct or will slow down in development. The IPAs are an association of little cottage industries. Everyone is duplicating each other's administrative effort. Eventually, I think doctors will make less and less money in the IPAs until they finally turn themselves into a staff model. All of the efficiencies are on the staff model side.

I think the mixed model has great possibilities because it combines the best of the IPA (rapid penetration and low initial cost) with the best of the staff model (organization capacity, flexibility, better-looking facilities, organized management, and the ability to hire good doctors and fire ones that aren't good). You can't fire anybody very well in the IPAs because the physicians all have their own practices, and if they don't contract with your IPA, they'll contract with someone else's.

Any health care system the United States develops will need medical providers. A new system might obliterate the health and accident insurance business, which is being obliterated anyway because it does not provide care; it is simply a marketing and administrative arm. The providers of care, that is, doctors through IPAs or medical groups or staff models, are going to provide the care. The staff model is really nothing but an organization of physicians and other health providers (a medical group) that receives payment on a capitation basis (a pre-agreed-upon sum per person per month) and not through fee-for-service.

The only thing I can say about all the plans to remodel the U.S. health care system that are being proposed is that the ones that will sell won't work, and the ones that will work won't sell--twenty or more in Washington, D.C., and state plans. We'll have to see what happens.

Contributions and Regrets

Hughes: Two more questions--don't move.

Gumbiner: I'm leaving. [laughter]

Hughes: No, you may not leave yet. What is your greatest contribution?

Gumbiner: What? Where? How?

Hughes: Whatever you like.

Gumbiner: I believe my greatest contribution is driving through the idea that management is the most important part of the health care delivery system, not the doctors, not the dentists, not the pharmacists, not the scientists, not hospitals, not insurance. Good management is the most important thing to get the medical care system where it's supposed to be--available, accessible, appropriate, and cost-effective.

Hughes: If you weren't limiting your answer to health care delivery, what would you say?

Gumbiner: I've had a lot of fun. I've always wanted to write a television series on putting together a reasonable health care system. I could go on for years because each episode would be about another crisis.

What is my greatest contribution to the field of health care delivery? My greatest contribution has to be the concept that health care, an indispensable and nondiscretionary service, must be managed by educated and skilled professional managers, not by technicians such as doctors or hospital administrators. Health care is more of a service than a science since, without availability and acceptance of that service by the people that it serves, nothing will happen, that is, health care will not be available to all of those people who need it. It must be physically and economically available. What good is a new cure or procedure if people don't know that it is available or cannot afford it? Only good managed care makes medical care available at the right place, at the right time, and in the correct form and price. This takes vision, judgment, implementation, and courage, and some of the "sacred cows" must be sacrificed.

What is left undone? The re-education of providers, especially doctors, and the education of consumers as to the options available to them in avoiding illness and maintaining emotional well-being and social good health. This will involve reorientation of medical school curricula and faculty thinking, as well as attracting a different type of individual to the field--hopefully a care giver rather than a scientist.

The full force of modern mass communication must be applied to educating the public to be more responsible for its own health condition, from controlling its own selection of providers, to an educated choice of treatments, procedures, and lifestyles. If we could only correct some of the misguided, wasteful media trivia to a more constructive purpose, we would be on our way to better consumer participation in good health.

Transcriber: Marta Wilson
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Berkeley, California

AN INTERVIEW WITH R. COLLEEN BENNETT

Interviews Conducted by
Sally Smith Hughes
in 1992



R. Colleen Bennett, 1993

BIOGRAPHICAL INFORMATION

(Please write clearly. Use black ink.)

Your full name Roma Colleen Bennett

Date of birth Sept. 8, 1934 Birthplace Wellsville, Utah

Father's full name OTIS L. CURTIS

Occupation Federal Employee Birthplace Logan, Utah

Mother's full name Margaret Cooper

Occupation Retirement Birthplace Wellsville, Utah

Your spouse Divorced

Your children Robert B. Bennett

Where did you grow up? Salt Lake City / Central Calif.

Present community Long Beach, CA

Education _____

Occupation(s) Executive Sec / Admin Assistant to
founder of FHP, Inc., an HMO

Areas of expertise Have been with FHP for 23 years
& know about growth of company

Other interests or activities My family

Organizations in which you are active None at present

INTERVIEW HISTORY

Colleen Bennett has been Robert Gumbiner's executive secretary and administrative assistant for twenty-four years. In 1969 she was seeking part-time work and answered an ad for a secretary to assist Dr. Gumbiner and his full-time secretary at a time when his role as medical director at FHP was expanding. Working quickly into a full-time position, she was--and remains--in a position to observe the company's development over two decades.

Despite the fact that the interviewer made three trips to southern California and each time had considerable contact with Miss Bennett, there was never the right moment to conduct an interview with her. Instead, the interview was conducted by telephone on February 25, 1992. Articulate and perceptive, she provides a thoughtful view of FHP's development and of the personality and work habits of its founder, Dr. Gumbiner. Loyal to him and his philosophy of health care delivery, she is somewhat skeptical of the direction the company has taken since his retirement as president in 1991.

Her association with Dr. Gumbiner continues since he remains chairman of the board of directors. Many mornings on her way to work at the FHP corporate offices in Fountain Valley, California, she stops at Dr. Gumbiner's home in Long Beach to consult about work to be done regarding his position as chairman. (Two secretaries at home handle his personal affairs.) Tolerant of a sometimes intolerant boss, she appreciates his ability to inspire--and demand--the best from people, herself included.

Sally Smith Hughes
Interviewer/Editor

October 1993
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Then we moved to southern California, and I thought at first that I would like to have a reprieve and not work for a while. After we came down here and got settled and my son was in school, I decided I'd worked too many years and I needed working to keep me stimulated. I was not used to staying home and being just a homemaker; I was used to trying to fill all roles. You know the saying, "Be all things to all people," at least to the ones I loved in my life.

Hughes: Did you immediately start working at FHP?

Joining FHP, 1969

Bennett: Yes. In fact, about six months after we moved to Long Beach and the school semester was well underway, I began looking at the newspapers periodically. We settled in a neighborhood close to the very first medical center that FHP had, which is on the corner of Palo Verde and Spring. I was looking at the paper one morning and discovered that they were running an ad for part-time help, which sounded like it would be wonderful. At that point my son was in the fifth grade, and I wanted to be home when he got home from school every day.

So I pursued it, and they were looking for an executive secretary to the medical director. (Dr. Gumbiner then called himself the medical director.) He had a full-time existing secretary, but they were expanding his role and they had just purchased what must have been the very, very first automatic typewriter. Whoever was hired would pretty much exclusively work with that, and it would be done for doctor recruiting purposes. Now, when I say the first automatic typewriter, I mean it was like an old player piano. It came with a tape and when you were typing, you would perforate the tape. Then for the repetitive letters that were basically all the same, with the exclusion of plugging in the salutation and the name and the inside address, you could program it to stop wherever you wanted to and then independently type in whatever was needed. So pretty much that's what I was hired to do, and did the first couple of years.

Hughes: What year was this?

Bennett: This was in 1969.

Hughes: What stage was FHP in at that juncture?

- Bennett: At that time we had two medical centers. The one where I worked was part medical center and part business office. Then they had the one in downtown Long Beach. I don't know whether that was purchased by the original partnership or whether that was later purchased by just Dr. Gumbiner. But I know that we only had the two facilities at the time. I remember that Dr. Gumbiner had just made a proposal to the state of California for a pilot project for Medi-Cal, which was very innovative and very well received. I think it was some time in late 1969 or early 70, the state granted us that prototype, and we operated with this pilot project and the state of California for many years.
- Hughes: That was quite a turning point for FHP, was it not?
- Bennett: It absolutely was. We had large contracts, especially for the size we were. We had some very prestigious programs--the federal employees' program, the state employees' program, school districts, and small businesses. We were covering a certain geographic area at the time, which included Long Beach. When we got the Medi-Cal pilot project through the state of California, it seemed like a shot of adrenaline, because we really moved forward rapidly then. This new program required more sophisticated systems, because we would pay on an individual basis, and they would pay up front for every member that we enrolled. We had to step up our marketing department so that it could go out and enroll the Medi-Cal recipients. Yes, it really was an infusion of capital which allowed us to go through a rapid period of growth.
- Hughes: Of course, that meant hiring more physicians and staff in general.
- Bennett: Oh, absolutely.
- Hughes: Were you still sending out letters on your automatic typewriter?
- Bennett: Yes. Recruiting was not a fun thing in the early years. We would take ads out in almost all major medical journals that were published in the country. I didn't know it at the time, but in the back of the journals, many doctors placed ads if they were interested in relocating to another part of the country. At that time, we were looking primarily for GPs [general practitioners], internists, and pediatricians. Those are considered primary care doctors and with a company like ours, that's the type of doctor you need the most of. So that's where we would get a lot of our leads. Then as they would respond, Dr. Gumbiner would look at their résumé or their CV [curriculum vitae], whatever they happened to send in, and give them an A, B, or C grade. From

that grading I would know what kind of an approach we would take next.

Hughes: Do you know what he was looking for?

Bennett: Well, in the beginning he always felt that he wanted older doctors; he didn't want young doctors just out of medical school since they would have grandiose ideas of what their future should be. He preferred to recruit doctors who had been in private practice for a while who had found out that running their own practice and trying to practice medicine, as well as be a businessman and an accountant, were not necessarily compatible lifestyles. He wanted physicians who had already tried the fee-for-service system and wanted a way to practice the simplest form of medicine. (By "simplest form" I mean without all the peripheral things that have to be done in private practice.) Such a system might be very appealing to the middle-aged doctor, not the younger doctor.

Hughes: Now he had to sell the HMO concept, which wasn't prevalent at that time.

Bennett: It wasn't even called HMO then. In the early years they were called Group Practice Prepayment Programs. The term HMO really was not coined until later, when a congressional figure started enacting legislation which would govern these types of organizations. Up until that time we very seldom ever referred to ourselves as an HMO. We were always Group Practice Prepayment.

Hughes: Do you know how Dr. Gumbiner went about selling that concept?

Bennett: I think like he has everything else, with a great deal of tenacity, drive, and belief in what he was doing. I think that he tried to stay very active politically so that he could convince legislators that the program was a worthy one. The pilot program that we had with the state of California was very beneficial because the state realized that for one set amount of money per enrolled member, it could get a lot of extra services. It guaranteed the company money up front--it wasn't always waiting to be paid--and the money came in with each enrollee. It was a very viable and feasible way to practice medicine, instead of paying the medical services for people as they went out into the fee-for-service community.

Hughes: Were you aware of the disapproval of organized medicine for prepaid group practice?

Bennett: No, because for one thing, with prepaid group practice being such a complicated business, it took me several years just to understand it all--all the agencies involved, both state and federal, that seemed to regulate what we did and how we did it. I understood the theory, but I didn't fully understand all the elements it took to make it work. All I know is, almost from the very beginning I certainly believed in the concept of what FHP was offering. I believed in the philosophy, especially from a consumer's point of view.

You know, when you stop and think about it, it seems logical that a doctor, if he doesn't have to worry about running an office and deal with the frustration of employees, time off, vacations, and so forth, it would be ideal. Not having to deal with the business end of medicine, he can just practice medicine and leave the management to someone else. Plus, he's guaranteed a certain salary. Part of that salary was built-in vacations, time off, and as far as I remember, the doctors were offered a pension program. These are all offerings that not many [non-FHP] doctors were afforded during their careers in the early years. They made it on their own merit or they were broke.

Certainly throughout the years we've had some absolutely wonderful doctors. I can attest to that because I've gone to many of them.

Hughes: Did FHP employees by and large buy into the prepaid group practice idea?

Bennett: Yes. I would say a very, very high percentage of employees were at FHP because they believed in the concept. Certainly it wasn't for the pay in the early years, because historically we've always been known to be a very low pay organization up until recent years. I think the thing that kept people there was that they really believed in what the organization was doing. Of course in those early years everyone had exposure to Dr. Gumbiner with all his energy dynamics. One of two things happened: you immediately believed in the company, where it was going, and what could possibly happen, or you believed in him because of his brilliance, his dynamics, and his energy. So it seemed for one or two reasons you were willing to forego things that you may have personally been looking for, in order to follow this company and see what developed.

Dr. Gumbiner's Administrative Style

Hughes: Well, say something about Dr. Gumbiner's administrative style and how he managed his day. I suppose there was never a typical day, was there?

Bennett: With Dr. Gumbiner there never is a typical day. Being typical or being routine is adverse to anything and everything he stands for. He gets very, very bored doing things the same way all the time as he needs more stimulation than that. In the twenty-three years that I've worked for him I can say that there has not been any kind of a routine day. The only thing that I have learned with time is that everyone gravitates to doing things in a way that they're most comfortable, and in an environment that's comfortable. Dr. Gumbiner, too, worked that way. There are certain styles of doing things that he's comfortable with and hasn't basically changed in many, many years.

Hughes: Can you give me an example?

Bennett: Just the fact of his coming into his office and having it set up in a given way, having his mail handled in a given way every day. If you ever did try to change any part of it, he didn't like it. It was unfamiliar to him and I guess he figured that he had enough challenges in his day and needed some things that were fairly unchanged and routine. So the standard part of work life remained pretty much the same for twenty-three years.

Hughes: Say something about his involvement in FHP.

Bennett: Dr. Gumbiner's involvement was all-encompassing. In the early years when I first started working for him, he practiced medicine one afternoon a week. He would come in, don his white coat, and see patients one afternoon (I think it was on Thursdays). He felt a loyalty to those patients that had been with him for quite a while. Some of them had been his patients since the time he first moved to Long Beach, and so he continued to see them. Then as the company got bigger, and more and more demands were made from the operational end, he had to stop seeing patients altogether and throw himself into the administration of the company.

He was always very, very active. I would say he was somewhat of a dictator. He believed that he was right, and he wanted things done his way, at least until it was proven that might not be the best way.

I remember every Friday we had physician meetings, luncheon meetings, and at FHP, if they make you use your lunch hour for a meeting, they will always feed you. And for many, many years that's what we did. The doctors would have a luncheon meeting every Friday, and they would discuss routine problems that were troubling them.

The operational end of the business had been pretty much turned over to Dolores Kellett at that time, who originally started out in the partnership as Dr. Gumbiner's nurse. She learned the business with him, and as it evolved and grew larger he eventually turned over the operational end to her, such as the nurses, the receptionist, trying to get the doctors to follow systems (not always an easy task). But she took care of the operational side while he was out selling the program, and finding other avenues where the company might expand.

Hughes: Did she have a similar philosophy?

Bennett: Oh, yes. Dolores Kellett believed in what he was doing as much as he believed in what he was doing. In the early years she kept a lot of the burdens of the day-to-day operation from his shoulders by taking care of things as they occurred. By the time she had worked for him a number of years, I'm sure she knew him well enough to know what his expectations were, so there was never any question that she was doing exactly what he would want her to do.

Hughes: Was he fairly good at delegating responsibility?

Bennett: Dr. Gumbiner has been so good at delegating responsibility that he delegates it to more than one person, which has its own set of problems. Dr. Gumbiner has never had a problem with delegation. The only problem is that sometimes he mentions it to more than one person, and will have two or three people simultaneously working on any given project. You learn after a while to check with those people that you think he may have also assigned the same project to. Once you determine who else has part of the project, you can collaborate, or you turn the information that you've gained over to them, or they to you. By checking and conversing one with another, you pretty much could eliminate any more than one person working on a problem. He always spread the wealth very well; he always had more than one person working on any one thing at any one time.

Hughes: Did he use multiple delegating for a reason? It could be a cross-check on what people come up with on a given problem.

Bennett: To use a term of his, it was "so things did not fall through the cracks." From a broad point of view, if one person didn't follow through out of those that he had mentioned the problem to, surely one of them would do it through to completion. That kind of duplication wastes a lot of time, but as I said before, he didn't want anything to fall through the cracks.

Staff Management Training Program

Hughes: About the time that you arrived, the management development program was instituted. Tell me about that, please.

Bennett: I believe in late 1970 or 1971, Dr. Gumbiner had been an adjunct professor at California State University at Long Beach. In his personal experience in trying to hire managers for FHP after it was organized and with the experiences he went through at Cal State, he realized that recruiting people with an adequate background for health care was very, very difficult. It was easy to get an MBA--they're weren't quite as plentiful then as they later became--but to get an MBA that was schooled in health care was next to impossible.

When he was an adjunct professor he realized that he was going to have to take these young MBAs and add to their education after their formal education. He would offer the better students in his class employment, but then tell them that they were going to have to go through a nine-month to one-year additional training to become educated in health care, specifically to FHP's way of health care. We used to bring these young people aboard two, three, four, or five at a time, depending on their availability, and then have them go through the program together. As they were near the completion of the program, FHP would bring in another wave and start all over again. The early program was such that they would spend time in every department with every manager. They would spend time in finance, in marketing, in medical, in every department that we had at the time. This was a hands-on experience for these young people as they were not only learning what functions each department performed, but also were gleaning information and expertise from the person who happened to be running the department. It was a very, very successful program.

Hughes: So the person running the department had the responsibility of teaching these people?

Bennett: Yes.

Hughes: It wasn't just passive observation.

Bennett: No, it was a very important function and part of each department head's responsibility in the early stages. A very critical part of their responsibility to the company was to assist in training these young men. I say "young men" because mostly they were men up until three or four years into the program, and then they started recruiting women.

In the beginning of the program, it was fairly difficult to recruit these young MBAs and tell them that the company wanted to send them back for additional training. Wasn't the world their oyster, and didn't they already know everything there was to know after receiving an MBA? Those that were willing to go along with the training program were very special people and committed to the cause. I heard a figure not long ago that in this year's recruiting effort there were well over one thousand people who were interested in joining our management development program.

It proved to be such a wonderful program for FHP, because as these young people graduated from the program, the company was growing fast enough that we'd absorb them into entry-level or mid-level management positions. Their contribution then was not only from an intellectual point of view as far as their education was concerned, but they also had a little hands-on experience in the health care field. They were extremely valuable to us. They were also very valuable to other health care companies, because we have always been plagued with our competition trying to abscond with these young people we had trained; they would try to hire them out from underneath us. Some of them did leave and went to other companies.

Dr. Gumbiner was believed to be an innovator in the health care field, and these MBAs wanted to be around the kind of energy, imagination, and leadership he displayed. If they did leave, many of them came back and would stay with the company for many years. We've had some wonderful, wonderful people that came to us as a result of that program. Despite the fact that they may have made a career choice not to stay with the company, that does not negate the fact that they made a contribution and added a wonderful dimension when they were going through the program.

FHP on Guam, 1973

Hughes: In 1973 FHP opened a program in Guam. Tell me how that came about.

Bennett: My recollection is that Dr. Gumbiner, before I came to the company, had gone to Guam to help Carmen Ness with a study regarding the need for a second hospital on the island. Apparently for many years they had been thinking about building another hospital, and, I think, it was planned to be an edifice for the bishop over there. The findings of this group were that there was not enough populace to keep two hospitals going (there was already a hospital on the island) and it was their advice not to go ahead with a new hospital. I don't think either one of the men knew at that time how their recommendation was received.

Later Dr. Gumbiner was contacted by, I don't know whether it was Sister Jean Marie Mencke, the bishop, or the government, stating that the traditional health care company, AFIA [American Foreign Insurance Association], knew they had a monopoly and a lock on the market and kept raising their rates considerably every year. This, of course, was not fair to the island people, so Dr. Gumbiner was invited to come over and make a proposal to the government for an alternative method of rendering health care to the citizens of the island. He made his proposal. Of course, it wasn't easy for Dr. Gumbiner to sell the program there, because Guam, for the size it is, is probably as political a place as you'll ever find.

But he ultimately convinced the government to give FHP a try, and the program proved to be very successful, and eventually AFIA left the island. We had to hire doctors on the mainland to send to Guam, but we couldn't recruit blindly. The doctors had to know going in that they were being recruited for the Guam region startup. I've talked to many doctors after their return from Guam and some were very anxious to get back, but many loved it over there. Some of them didn't like the isolation, nor the fact that Guam was an island and had a given geographic area, which made them feel claustrophobic. But others loved the sense of freedom and felt it was a wonderful place to raise their families. Two or three years later, HML, the insurance company that FHP had formed on the mainland, entered the scene in Guam. In fact, HML of Guam is still an operating company.

Hughes: I thought FHP eventually introduced an IPA on Guam.

Bennett: Maybe it was a form of IPA. They went to all the doctors on Guam and tried to get them to sign a contract to see HML patients. So

in a respect, because the doctors were under contract, it was like an IPA, but it was administered more like a traditional insurance company.

Hughes: I know there was an incident in which the physicians who had contracted with HML threatened to resign.

Bennett: When all of the doctors were recruited, apparently there was one doctor who happened to be off-island at the time. His name is Ernesto Espaldon. I guess the people of Guam are a very proud people. Dr. Gumbiner says they placed telephone calls to Dr. Espaldon's office; Dr. Espaldon maintains that there was never any contact with him. There was a feud that started to brew between the two men because Dr. Espaldon felt left out. I guess because of the pride of the culture, he just couldn't let it go. This mini-war went on and on, and he did everything in his power to bring HML down, including trying to organize the doctors against HML.

I used to think that every time Dr. Gumbiner left the office here in California, a huge problem would occur in Guam. One of the problems that occurred was all the doctors resigned from HML at the same time. I can't remember now where he was, whether he was in Europe or traveling elsewhere, but I remember as soon as he returned he had to immediately get on a plane for Guam to see what he could salvage out of the mess that had been created. And in fact, once he was over there, and once they negotiated, he did get most of them to come back. Dr. Espaldon is still the single entity out there who has a bruised ego and will not negotiate anything with FHP and/or Dr. Gumbiner.

FHP in Utah, 1976

Hughes: In 1976, FHP moved into Utah.

Bennett: Yes. I think Diane Moeller and Irene Sweeney were really responsible for inviting FHP into Utah. Utah Group Health had received a government grant of some kind to set up a health care organization for the needy. They had built a lovely new building to provide the care, but were running out of money because of poor management.

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Bennett: The group needed someone with some management talent. I think that Irene had attended a seminar at one time where Dr. Gumbiner was in attendance.

Dr. Gumbiner/FHP were invited into Utah with a one-year management contract with Utah Group Health, to help turn it around. There had been a built-in provision that if at the end of one year, FHP wished to purchase the group, it could do that. Dr. Gumbiner could see the potential in Utah because, other than traditional insurance or fee-for-service physicians, there really was no alternative or option. There was no additional way of offering health care to the citizens there. FHP did ease the burden of Utah Group Health and was allowed to purchase the plan.

Irene Sweeney had been a member of the board of directors of Utah Group Health, and when FHP acquired the plan she became a member of the board for FHP, Inc., and has been ever since. Some of the people that had originally worked for the group stayed on with FHP, some are still there, and others have been slowly diluted with time.

There were two facilities in Utah; one was in the old county hospital, with very limited quarters, which they were leasing from the state of Utah for one dollar a year. The other facility was the Greenwood Center. It was a lovely new center south of Salt Lake City, between Salt Lake and Murray. FHP acquired the plan, but they weren't able to turn it around and make it profitable quite as soon as they hoped (in two years), which was how long they had given themselves to do this.

Whenever FHP does anything, they have to do things the FHP way. The same thing was true when we went to Guam. And the FHP way is that you have clinics that do not look like clinics, and are never referred to as clinics. The centers do not have the traditional light green or white interiors; instead they are all done in very fashionable colors. From the very beginning we always received a lot of acclaim and accolades for the look and comfort of our facilities. Consumers felt good, and did not feel like they were going to a clinic when they came into our facilities. And of course part of the mode in going into any new area is to give it the "FHP look." Even in the new Greenwood center, which was fairly new when FHP purchased it, they changed wall coverings, repainted to get away from the sterile look, and added the personal touch of individualized art work--which has always been a key decorating element in every facility we've ever opened. In the early years our facilities were essentially a trademark for FHP, and were self-identifying from the outside and the inside. You could remove the name from the exterior of our

buildings, go in one, and it would be self-identifying because of the way it was decorated and laid out.

Hughes: Of course, this was an added expense.

Bennett: It was an added expense, but Dr. Gumbiner believed you sometimes have to spend money to make more money. FHP was offering a kind of health care which was virtually unlike any that had been offered before. But we also had above-average facilities in which our patients could come and visit their doctor. I think the up-front money was marginal versus the return that FHP eventually received from its investment.

Federal Charges of Diversion of Funds, 1976

Hughes: Do you know about the accusation that FHP and four other health care plans had funneled federal and state money appropriated for Medi-Cal into for-profit affiliates?

Bennett: The General Accounting Office [GAO] did an audit, and investigated several HMOs in California. I don't know how widespread its investigation was, whether it was throughout the country or primarily in California. Some of the HMOs it investigated were found guilty of fraud and of funneling federal and state money into supporting a grandiose lifestyle of the founders, presidents, or CEOs of the HMOs.

In FHP's case, we were never found guilty of a wrongdoing, but the study indicated that we had a very complicated infrastructure. I remember in the early days FHP had a terrible time finding financing for what it wanted to do. It couldn't go to a bank to apply for a loan, and once a bank found out we were an HMO or a group practice, it would want to know what that was. In those days a bank would not loan a company such as ours any more than the founder was worth. It was very, very difficult for us to get financing. So Dr. Gumbiner would form limited partnerships in order to generate money, which would enable the company to buy a plot of land or build a building. Then he would form another limited partnership when another project was in the making. On one site, you might have two limited partnerships, one to build the building and one to purchase the land. That's what GAO meant by infrastructure.

There were several of these partnerships in existence at the time we signed the Medi-Cal contract. Because these partnerships did not appear to be a problem at the time we signed the Medi-Cal

contract, FHP concluded there was nothing wrong with this type of operation, so we continued forming limited partnerships afterward. The California attorney general wanted FHP to dissolve every limited partnership that came to fruition after FHP signed the Medi-Cal contract, but all partnerships existing before the contract we were able to keep in place. I know that because I had invested in one of the limited partnerships and was forced to sell when the partnership was dissolved.

Hughes: And the state attorney general sued as well.

Bennett: Yes. You see, everything sprang out of that initial GAO report. Dr. Gumbiner and Andy Campbell, who was our director of finance at that time, were called back to Washington D.C., to testify before Senator [Sam] Nunn's investigating committee. Nunn was the chairman of the committee looking into the allegations against the HMOs. There was extensive testimony that came out of those hearings, in fact, I still have a green book of all the testimony.

The senate committee did not find FHP guilty of any wrongdoing, but from that, then the attorney general of the state of California got on the bandwagon. I don't completely remember, but I think the main problem was our reporting agency; the state of California believed that we should be reporting to the attorney general, and Dr. Gumbiner believed the Department of Corporations [DOC] had jurisdiction.

Hughes: What difference did it make?

Bennett: Well, it made a big difference as far as how we conducted business, because when we reported to the Department of Corporations, it did not seem to have a problem with these limited partnerships. The existence of the partnerships was fully divulged at the time but the DOC did not say anything about them. But the attorney general's office indicated that had we been reporting to them, it never would have allowed the partnerships to exist, because of conflict of interest.

Hughes: Did FHP expend a good deal of time and energy on these battles?

Bennett: Yes. In fact, the attorney general's suit was just concluded in either 89 or 90.

Hughes: Really!

Bennett: It went on that long. The state was being as tenacious as a dog with a bone, and so was Dr. Gumbiner and the company because we felt we were guilty of no wrongdoing. If we were, then it was up

to the state of California to prove what we were guilty of. Dr. Gumbiner just believed in this inequality so firmly that he was willing to take the time, the management talent, and spend the up-front money to prove his stand. Also, he didn't want anything on our unblemished record. Because of Dr. Gumbiner's manner--he has so much self-assurance all the time that he's right--he oftentimes rubs people the wrong way if they don't have his level of confidence. To engage in a battle with him gets some of his adversaries so frustrated they're willing to carry a grudge far beyond where it should have gone, just because it becomes a personal vendetta. I believe that's what happened in this case. Even though it doesn't sound exactly right that an attorney representing the state of California would have a grudge or a vendetta against a corporation, I basically believe that was part of why this matter was allowed to get out of hand.

Hughes: Well, that's interesting.

Bennett: Had Dr. Gumbiner had a different manner, a different style, less tenaciousness and more willingness to negotiate, it may not have ever gotten to that. But he believes what he believes, and he's willing to put his money and time where his mouth is.

Hughes: He also seems to like a good fight.

Bennett: Oh, he loves a good fight. He loves being in the middle of activity and likes watching it going on around him. It's almost like it's part of his life's blood and he really gets an adrenaline high from competition.

Matrix Management System

Hughes: In the early eighties, Dr. Gumbiner introduced the matrix system. Could you tell me about that?

Bennett: I know that the matrix system within this company worked very well. Dr. Gumbiner knew human nature enough to know that as a company prospers and peoples' positions with that company become elevated, the people become more elitist and have more authority. Thus there is a tendency to build little empires within a company.

Matrix, I believe, was first used in the aerospace industry and, in essence, that's what Dr. Gumbiner created at FHP. Every single person in this company at one time had two people they reported to. In my case, because no one was excluded from this

matrix, I not only reported to Dr. Gumbiner but also reported to an office manager. The office manager was responsible for coverage when I was out, my willingness to be a team player, whether or not I had excessive absences or tardiness, and so on. Dr. Gumbiner, on the other hand, evaluated the quality and timeliness of my work, the responsiveness of my attitude, judgment, and so on.

Hughes: A written evaluation?

Bennett: Yes. Every time anyone was reviewed, they were reviewed by two different parties. A lot of people in the company didn't like that because it was cumbersome. In a lot of instances the matrix system prevented people from using people or getting close to people for purposes of their own advancement in the company, since there were always two people who had to agree how good you were, not just one.

The matrix system certainly grew; it expanded and developed along with the company. As you probably know, Dr. Gumbiner had not been retired very long at all when the matrix was eliminated. As time went on and the company became larger, there were people who believed that the matrix was extremely cumbersome and in some aspects was more expensive than just the straight-line management philosophy.

Hughes: In 1983 the senior plan was introduced, which was another major step.

Bennett: Between 1984 and probably 1986, we hit the fastest single growing spurt in our history, largely because of the Medicare plan. Before coming to work for FHP, John O'Connell had put together the paperwork for a risk management HCFA [Health Care Financing Administration] contract for Fallon Group Health, which was located in the Mideast. He was very familiar with the routine and the formality of filing these papers, and after coming to work for FHP, he did a wonderful and a very diligent job in filing all the necessary papers (which was extensive). As a result, we became one of the senior Medicare risk contractors, and one of the first, if not the first, in the state of California. It was a very prosperous program for us.

Independent Practice Associations

Bennett: Within just a matter of months, we also branched out into a mode of business that we had never done before, which was the IPA.

Prior to that time we were strictly a staff model [HMO], which means that every single person is working for the company. They were not under contract with us, but they were employees and received all benefits of being an employee of FHP.

Of course the IPAs were different. We would go into a given community, contract with a hospital and contact with the physicians in that community to see our patients for a predetermined amount of money for a given procedure. It was an agreed-upon fee schedule or percentage of the dollar taken in. So that was a completely different mode, one which we had really not tried other than on a very small scale in Guam.

Hughes: Why was the IPA introduced?

Bennett: Because it offered a whole new avenue of exploration and line of business. The staff model was a wonderful concept, but we had pretty much saturated the market within the geographic area that we covered. The IPA offered us the ability to move and grow faster in areas outside of our immediate geographic area. We would supply the management expertise, but we didn't have to have money for facilities and we weren't spending money on salaries for physicians.

The very toughest part in the early history of the IPAs was getting a good negotiating team going--negotiation was everything in the IPAs. Certainly FHP was not too generous in the beginning with the contracts. We had David LeSueur, one of the senior vice presidents and known to be one of the toughest negotiators FHP had, negotiating for us. He negotiated some very lucrative contracts for FHP, which later we've had to renegotiate because they were not entirely equitable to all parties. The monies now are much more evenly distributed between FHP, the doctors, and the hospital. But this venture was a whole new venue for FHP.

FHP's Conversion to For-Profit Status, 1986

Bennett: We had prospered to the point where we were looking for other avenues where we could grow and spread our philosophy of health care. At that point we were still nonprofit, but shortly after that we decided to convert and file for for-profit status, which was a very, very lengthy process.

Hughes: Do you know the thinking behind that?

Bennett: That's something that I can't share with you, because I really don't know the thinking behind it. The only thing that I ever came up with is that the for-profit status made it possible for FHP to get cash for expansion purposes. We had two programs that we were working on--with all the potential in the world--and their success or failure depended on finance and management as to how far we could go with them. The staff model mode, regardless of how large we became, was only generating a certain amount of revenue. But going through the conversion and going for-profit--as costly and time-consuming as it was--would give us the cash we needed for expansion.

By that time, we had filed with the state of California for a bond to build a hospital in Fountain Valley, FHP's first hospital. That was also something that was very time-consuming. When we applied for the hospital bond we once again became more mired down with California politics. First of all, there was a certificate of need that controlled the use and the building of hospitals in the state. They were going to deny us permission to build until they learned this hospital would serve only FHP membership. The reason for the certificate of need is to regulate how many hospitals, and where. It took us quite a while to get around the certificate of need inasmuch as we had to convince the state that our hospital would not be serving the community as a whole, only our own members. We would be servicing patients from the north, east, south, and west of the geographic location, wherever our membership was within our geographic area.

Finally we got past the certificate of need, but then we had to apply for a bond through the state to build the hospital; I think it was for \$25 million. This proved to be a very, very political maneuver, because we had to use one of the big eight accounting firms that the state of California used. Jesse Unruh was the big daddy of California politics at the time, and he seemed to orchestrate whom we had to use, when we would use them, and how much they were to be paid. This is another instance where Dr. Gumbiner got his dander up and didn't want to go along with what the politicians were saying. As far as he was concerned, they had no right to tell us what accounting firm we should use. As it turned out, it appeared there was some underlying political reason why Jesse Unruh was insisting that everyone use one of these eight accounting firms.

Hughes: What was the reason?

Bennett: Suspicion was, there must have been a kickback to him.

This was another episode where Dr. Gumbiner was bucking the system and bucking the flow of the way things had been done before. This is what's gotten him into a lot of trouble; he believes right is right, and he's always been tenacious enough to let his desires, wishes, and thoughts be known. He has been willing to follow through to the end, is not easily intimidated, and has not fallen to the wayside as many other people might have.

Hughes: Colleen, do you know anything about Ultralink?

Bennett: No. That's a venture that we've just been into in the last few years. All I know is that it has taken us nationwide and dealing with large employer groups. If we get a big account like McDonnell Douglas which is stationed nationwide and has employees nationwide, then we make arrangements for other health care organizations or other HMOs in the country to see their employees. That's about all I know about it, Sally.

Hughes: Well, that's a start.

Bennett: I know that it seems to be a very viable and working arrangement right now. The people that form Ultralink have a wonderful attitude and really believe in what they're doing. I think that we were sort of forced into it in order to get the large national accounts we wanted, such as McDonnell and some of the big hotel chains, which wanted to know that their employees were going to be covered outside of California, Utah, New Mexico, or Arizona. They wanted to know all of their employees would be guaranteed coverage through some form of HMO.

Office of the President

Hughes: Some years ago Dr. Gumbiner formed the office of the president. Can you tell me what the purpose was?

Bennett: I think as we became larger, Dr. Gumbiner realized that FHP was getting to be far more than he could handle. He wanted the time to be innovative and do the things that he does the best; that is, to think of new ideas for the company and then chart its direction toward that end. He was wise enough to know that he didn't have time to do that and still take care of the everyday business of the company. When W. W. Price joined the company about ten years ago is when this office of the president was instituted.

Bill was hired as a senior vice president and had been with the company only a few months when Dr. Gumbiner brought in David LeSueur from the Utah region to be another leg of that office of the president. Then probably a year, year and one-half later, Burke Gumbiner became the third leg of the office of the president. This is strictly my own thought on this: I think Dr. Gumbiner wanted to create an old-fashioned gladiator's arena and to create a competitive environment in which the cream would rise to the top. He wanted to be able to determine the strengths and the weaknesses of these three men, and so he created this fishbowl in which they performed and had to function.

Hughes: How did they respond?

Bennett: It was terribly competitive and, at times, it bothered some more than others, depending upon the individuals' self-assurance and self-worth. Some felt very confident that they could do whatever task was put before them. They were each given specific responsibilities, but they had to jointly meet and agree on basic philosophy changes, benefit changes, or any other changes they were advocating regarding the direction of the company. And of course, all of these recommendations would have to be approved by Dr. Gumbiner. It was a new concept; to keep from appointing any single person to succeed him, he created the office of the president. When he went on a lengthy sabbatical for three or four months, it was actually the office of the president that kept the organization functioning while he was gone.

FHP After Dr. Gumbiner

Hughes: Dr. Gumbiner retired in November, 1991. Do you have any comment to make about the changes that have occurred since then?

Bennett: Because I've worked so long with him and I believed in him and what he wanted to do, this is going to be very hard for me to put into words. He turned a lot of people off with his mannerisms, his demands, and because he was very dictatorial. He knew this industry so well, and he had a second sense about what was right. He certainly knew what was right for this company. No one before him, no one during his time, and certainly no one since his time knows this company like he did, nor do they have the intuitive sense to take the company in a direction that is best. He now is recognized as being an expert in the HMO field, politically, nationally, and he has a certain reputation internationally. It's not just FHP or just me that appreciates his talents and his business acumen, but I think it is recognized by many.

In my purview, the way in which the company will suffer the most is that because of Dr. Gumbiner's own dynamics, people were given only certain reign and certain freedom; otherwise they had to be totally accountable to him. Since he is no longer here on a day-to-day basis, it seems like people are taking a lot more freedoms than they may be prepared to handle. Therefore, I feel that the company is far more disjointed than it has ever been before. I may have an isolated viewpoint, but I feel very strongly that the company has changed a great deal and will continue to change without Dr. Gumbiner. He supplied that one element (the glue) that seemed to keep it all together.

Evolution of FHP

Hughes: Well, my last question concerns the evolution of FHP organization.

Bennett: I think fundamentally Dr. Gumbiner started out with a vision and a dream: "Wouldn't it be nice if things could be better in the health care field than they are?" Through his own drive, tenacity, and belief in himself, he was willing to risk a great deal of his personal time and probably a certain amount of his personal wealth to pursue that dream. And because he had such a strong personality and had such dynamics, he was able to convince enough people of that dream who were willing to pursue it with him.

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Bennett: I think anyone enjoys being around a leader who is so self-confident. These are the people who know they are going to succeed in their chosen areas, but just can't tell you exactly when. But the idea that they're going to succeed at what they want to do never leaves their mind. Because of that self-confidence, Dr. Gumbiner attracted a lot of people who were willing to work hard and to spend a lot of time, and, in some cases, to sacrifice a lot of their personal life to help him pursue his dream because they wanted to be part of it. I think that as a company grows, things take on a life of their own, and sometimes that's good, sometimes that's not so good, depending upon the leadership. I think there have been times when Dr. Gumbiner has looked at this company and realized it has far exceeded anything that he ever hoped it would and could be.

The company is now slowly getting away from a lot of its basic philosophies, because, I guess, every man wants his day in

court and wants to see what he can do himself. Now we have one man, the CEO, who leads the company, along with a committee. It used to be called the executive management committee, but is now referred to as the executive operating committee. I think all these people will want to see what kind of a mark they can leave on the business or on this industry. I think that what we're going through now is an evolution from a dictatorial-type leader to one where decisions are made by committee. I don't know that we will ever have, at least in my tenure with the company, a single person running it again.

Hughes: Well, that's the end of my questions. Is there anything more that you would like to add?

Bennett: Mainly that working for FHP for all these years has been an experience unlike any I probably could have had other places. It's been something that has been challenging personally as well as long-range for me. I haven't enjoyed every minute of it, but I can say that I've enjoyed the bulk of the time that I've been here, and certainly working for Dr. Gumbiner personally has not only made me, but forced me, to be the best person I could be on any given day. I don't know that he's always known that or always appreciated that, but I know in my heart of hearts that has been the case--because he would not accept anything less than that.

Being part of and watching FHP grow has probably been one of the more memorable things I will ever do. I will never forget the wonderful people who have worked for this company throughout the years. They haven't been just good or just nice people, they've been wonderful people, and they've all left their mark in some way or fashion. The company is richer for having had their exposure and their experience.

Hughes: I think that's a nice place to stop. Thank you.

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AN INTERVIEW WITH BURKE F. GUMBINER

Interviews Conducted by
Sally Smith Hughes
in 1992



Burke F. Gumbiner, 1993

BIOGRAPHICAL INFORMATION

(Please write clearly. Use black ink.)

Your full name Burke Franklin Gumbiner

Date of birth 10/25/50 Birthplace Long Beach, California

Father's full name Robert Louis Gumbiner

Occupation Entrepreneur Birthplace Indiana

Mother's full name Josephine Gumbiner

Occupation Philanthropist Birthplace Indiana

Your spouse Kera

Occupation Interior Design Birthplace Philippines

Your children David Joshua; Tali Ruth; Shiri Eve Leah

Where did you grow up? Long Beach, CA

Present community Corona Del Mar

Education University of California at Santa Barbara, BA, Political Science, 1972

California State University at Long Beach - MBA, 1977

Occupation(s) Senior Vice President of FHP, Inc.

Areas of expertise HMO Administration

Other interests or activities Skiing, bike riding, traveling, scuba diving

Organizations in which you are active _____

INTERVIEW HISTORY

Burke Gumbiner is senior vice president, associate chief operating officer, and member of the executive operating committee of FHP. He is also one of Robert Gumbiner's four children.

Mr. Gumbiner graduated from the University of California, Santa Barbara in 1972 and was persuaded by his father to join FHP as a sales supervisor. In 1975 he was promoted to marketing manager of FHP's new Utah region. Two years later he returned to school to complete a master's degree in business administration. After an interlude with two other HMOs, he returned to FHP as vice president of marketing and then executive vice president of Health Maintenance Life Insurance Company, a subsidiary. In 1981 he became vice president of marketing at FHP, and five years later was promoted to senior vice president.

Mr. Gumbiner was interviewed in his office at FHP headquarters on February 18, 1992. He provides a perspective on the development of the company which is only incidentally tinged by the fact that his father founded and ran it for most of its history.

Sally Smith Hughes
Interviewer/Editor

October 1993
Regional Oral History Office
The Bancroft Library
University of California
Berkeley, California

VI INTERVIEW WITH BURKE F. GUMBINER

Background

[Date of interview: February 18, 1992] ###

Hughes: I would like to know where you were born and educated.

Gumbiner: I was born in Long Beach, California, and I was educated in a variety of places. I have a bachelor's degree from the University of California at Santa Barbara in political science, and then I have a master's degree in business administration from California State University at Long Beach. But I also spent a year of my MBA at the University of Utah, and I spent a couple of semesters on World Campus Afloat sailing around the world, and that counted toward my bachelor's degree. I spent a semester at Chapman College, but I managed to get all those credits to count toward the right degree.

Hughes: Where is Chapman College?

Gumbiner: In Orange, California, but it was running World Campus Afloat at the time.

Hughes: Is that program intended for people with interests in political science or world affairs?

Gumbiner: Yes. It was good for people who liked to travel and see other cultures.

Hughes: You went all the way around the world?

Gumbiner: Yes, and attended classes on the boat.

Hughes: As an undergraduate?

Gumbiner: Right.

Hughes: You did a master's degree in 1977?

Gumbiner: Yes, at Cal State.

Hughes: What were you thinking of doing as a young person?

Gumbiner: I initially got a poli sci [political science] degree and was thinking I would go to law school. Then I switched over and I went to work for FHP after I got my bachelor's degree. Since I had enjoyed traveling so much on World Campus Afloat, I saved up some money and took a backpack around the world for a year and ended up in Guam working for FHP.

Joining FHP, 1972

Hughes: Did you have any qualms about working for an organization with which your father was so strongly identified?

Gumbiner: No. It's a dynamic organization. But after I got my master's degree, I did go work for a couple of other HMOs to get some outside experience.

Hughes: With the idea of eventually coming back to FHP?

Gumbiner: Right.

Hughes: Which HMOs?

Gumbiner: I worked for Roosevelt Health Plan in Chicago and Rockridge Health Plan in Oakland.

Hughes: Please compare them to FHP.

Gumbiner: I found out that FHP was light years ahead of the others at that time.

Hughes: In what sense?

Gumbiner: In its development. It had been in the business longer and just knew how to do things better.

Hughes: How many years were you with those other HMOs?

- Gumbiner: I was with them for about a year. Then I was recruited by my father because he had started Health Maintenance Life Insurance Company, which is now called FHP Life, that needed somebody to do the marketing and sales. I was working in Oakland at the time, and he was visiting me regularly and finally enticed me back down here.
- Hughes: Did you know anything about the indemnity insurance business?
- Gumbiner: The HMO business and the indemnity insurance business have a lot in common. We were selling against the indemnity insurers so I learned a lot about how it works. In addition, our concept was an indemnity insurance plan designed to be combined with the HMO, so people have a choice of either HMO doctors or their own doctor.
- Hughes: So it was never looked upon as a competitive entity?
- Gumbiner: No. It was looked upon as a companion entity.
- Hughes: You were in marketing?
- Gumbiner: Yes, marketing that plan, and then eventually I became executive vice president of the insurance company.
- Hughes: Had you been marketing for the other organizations?
- Gumbiner: Right, primarily in marketing.
- I initially was a sales supervisor for FHP for the Medi-Cal program. Then I was a group sales representative in Guam and in California. Then I was FHP's first marketing manager in Utah. Then I went back, did the traveling, got my MBA, came back and when I got out of the MBA, I went to work for the other HMOs and then came back in the insurance company.
- Hughes: Do you want to talk about selling for FHP's Medi-Cal program?
- Gumbiner: I started out doing door-to-door sales for the Medi-Cal program, signing up people in the ghetto. My father didn't want to make it too easy on me when I came to work for FHP so he gave me a fairly tough job that I could cut my teeth on. Then I was promoted to a supervisor of sales representatives who were doing the same type of thing. That's where I worked prior to doing the traveling. Then when I came back from the traveling, I ended up in Guam as a group sales representative where we sold FHP to companies on Guam.

Hughes: I imagine that was an entirely different kettle of fish than marketing Medi-Cal in the ghetto.

Gumbiner: Right.

Hughes: What were some of the problems that you ran into in the ghetto?

Gumbiner: One of the problems is that the people who are on welfare don't readily come in to sign up for an HMO. They don't read; a lot of them don't respond well to direct mail. A lot of them don't have telephones, so there is no way to contact them by phone. The state of California found out that the only way to get these people to join an HMO was through actually going to their homes on a door-to-door type program. It was an interesting program. I think it did a lot of good for the people that we signed up; it gave them health care.

Hughes: Was the door-to-door approach successful?

Gumbiner: Yes, it was successful. We tried different ways of trying to get people to sign up. We were successful. We were the first [HMO-based Medi-Cal] plan in California and we had a lot of people sign up. However, the problem with that whole program was that the state continued to cut the funding so that even if you are on welfare right now in the state of California and you are entitled to benefits, there are very few doctors that will see you. The state has cut the payments so much that doctors refuse to see people on Medi-Cal. Now they have to go to the county hospital, and you get very poor care even though you have extremely high benefits. You've got better benefits than anybody but no doctor will take those benefits because of the low payment from the state.

Hughes: Not a good situation.

Gumbiner: That's part of the health care problem.

FHP on Guam, 1973

Hughes: What was the situation like in Guam?

Gumbiner: It was selling to companies. We were the first HMO on Guam. We had the government of Guam as our biggest contract. We enrolled half the employees in the government. Then we enrolled companies. We were able to deliver, because it was an HMO and we were the only one. We could deliver higher benefits for a

lower cost and we had better quality doctors because we had doctors who were trained in the United States that we brought over from the U.S. The majority of the other doctors were trained in the Philippines. People perceived and it was acknowledged that the U.S. medical schools were better. So we had the advantage of doctors that were perceived as being better, plus better benefits and lower rates.

Hughes: Did you recruit doctors or did you shift them from the mainland?

Gumbiner: We recruited and shifted, but mainly recruited.

Hughes: How difficult was that?

Gumbiner: Not difficult. There were a lot of doctors that wanted the adventure of going to Guam but also wanted to work for a U.S. company, have good benefits and a good salary, et cetera.

Hughes: You more or less transplanted the staff model which had already been successful in southern California?

Gumbiner: Exactly.

Hughes: How were the Filipino doctors integrated?

Gumbiner: We had some Filipino doctors. We have some now. But our requirement is that they have to do their residency in the U.S. and have a U.S. license.

Hughes: Health Maintenance Life was a force in Guam, was it not?

Gumbiner: Yes, it still is. In fact, Health Maintenance Life is a force here now. It's called FHP Life. But Health Maintenance Life was the original company. After we had the government of Guam business for a year, the insurance company, which was AFIA, dropped out of the business. They made the mistake initially of trying to come in and match our HMO-style benefits, which caused them to lose a tremendous amount of money the first year.

Hughes: Is that an American company?

Gumbiner: Yes, it's a conglomerate of Aetna, Firemen's Fund, INA (INA became Cigna), and it was called AFIA. They lost a lot of money so they dropped out, and the government of Guam didn't have any insurance company. Nobody would bid on the business. We put together Health Maintenance Life, which had been chartered in California, and brought it over to Guam and established it. We signed up all the doctors that weren't working directly for FHP on an IPA and took over the entire government of Guam contract.

Hughes: Was that the first time that FHP had used an IPA?

Gumbiner: Yes.

Hughes: Were there bugs?

Gumbiner: There were a fair number of bugs. The doctors tried to conspire to get rid of us but we fought that off. We sued them for a million dollars apiece. We got them to back down.

Hughes: [laughter] I think that might. There was a newspaper article about a threat of doctors to resign en masse.¹

Gumbiner: That's why we sued them. We sued them for violation of the Sherman Antitrust Act because they conspired together to resign en masse, which is a violation of the antitrust laws.

Hughes: What happened?

Gumbiner: They didn't resign. They ended up staying with us and we held the HML together.

Hughes: That was quite a change from the staff model to an IPA in terms of control.

Gumbiner: Exactly. But we didn't want to go in with just a straight insurance company with no controls at all.

Hughes: Anything more to say about your time in Guam?

Gumbiner: Well, it was interesting. FHP is still successful over on Guam.

Hughes: Why was the decision made for a relatively small southern California company to start a plan thousands of miles away in the middle of the Pacific?

Gumbiner: Because my father was an avid scuba diver. They have excellent scuba diving over in that region, and he would scuba dive on Truk and then fly over to Guam and talk to the governor and try to sell him on an having an HMO. After five years, the governor got a 40 percent rate increase from his insurance company and decided he needed FHP. [laughter]

Hughes: It was as simple as that.

¹"Ortiz, Espaldon sued by HML," Pacific Daily News, October 29, 1977.

Gumbiner: He called my dad up and said that he would give him the government contract. The bishop of the Catholic Church had a medical center over there, the Catholic Medical Center, that was going broke. The bishop got together with the governor and said, "We'll give you the medical center. It comes with three doctors." We were off and running. We leased the medical center from the bishop; we still lease it. It used to be called the FHP Guam Catholic Medical Center. After a number of years, we dropped the 'Catholic,' but we still lease that same center. We've built three more centers since then.

Hughes: Three centers on Guam or on other islands?

Gumbiner: We have the one center that we originally leased and then we built another administration and dental center next to it. Then we have a center in Dededo which is in the northern part of Guam, and then we have a center on Saipan.

MBA and First Job in the Industry, 1977

Hughes: What happened after Guam?

Gumbiner: After Guam, I completed the first year of my MBA at the University of Utah.

Hughes: Was that your idea or were you getting a little shove from your father?

Gumbiner: No, I wanted to complete my MBA. He was encouraging me to do it but I wanted to do it, too. An MBA was the entry-level requirement to get into senior management.

Hughes: Were you fully intending to come back to FHP?

Gumbiner: I thought I might. I was not 100 percent sure.

Hughes: Did you look at other job opportunities?

Gumbiner: Yes. My talents were really in demand--sales in an HMO. When I got out with my MBA, I got a job right away. When I graduated, I only had a weekend off and then I flew to my job. So people who had HMO experience, especially in the marketing and sales area, were very much in demand so I could get a job at a much higher salary than somebody that just graduated with an MBA without any experience.

So I definitely decided this industry was so good, I was not going to change industries. But I would only take a job in an area that FHP didn't compete in. I didn't want to be competing directly with FHP. So my first job was in Chicago.

Marketing Manager for FHP in Utah, 1975

- Gumbiner: I'm getting ahead of myself. I went back and completed one year of my MBA and then came back to California and worked in California as a group sales rep for FHP, selling to companies in California, signing them up on the FHP HMO program. Then FHP coincidentally took over Utah Group Health Plan in Utah, on January 1, 1976. I went there with a team of three other people as the initial team from FHP. I was in charge of marketing. We had a general manager, a woman in charge of operations, and a doctor who was the medical director. The four of us went up there as the team that managed the acquisition. It was actually a merger of two nonprofit corporations.
- Hughes: The Utah Group had been having problems. So you inherited those, presumably?
- Gumbiner: Yes. They were running out of cash. They only had a couple of months to go before they were going to have to close the doors. They wanted somebody to pick up all the liabilities and the assets, to basically take it over completely and be responsible for whatever past debts they had incurred. The only two companies that expressed an interest were ourselves and Blue Cross of Utah. But Blue Cross didn't want to pick up the debts; they only wanted to pick up the assets. We agreed to pick up everything.
- Hughes: Why?
- Gumbiner: We thought it was a good opportunity and we felt that just by making some changes we could turn the thing around.
- Hughes: How long did that take?
- Gumbiner: It took longer than we thought. It took about five years. We were able to go in there and make a positive impact.
- Hughes: What were some of the problems?
- Gumbiner: They had no marketing. They had facilities and staff but they didn't have the enrollment to cover them. They didn't have

revenue. So we went in there and did the marketing and brought in the membership.

Hughes: Utah is a fairly conservative place and the HMO concept was still relatively new. Was it difficult to sell?

Gumbiner: Well, we sold our first two accounts by threatening to sue the state under the state HMO law to get them to offer the HMO. The HMO law stated that any group of employees within the state government or political subdivision of the state government that wanted an HMO had a right to an HMO. That applied to the state of Utah and the University of Utah. So we got a group of employees to request the HMO and then when the state refused to offer the HMO, we threatened to sue them under the HMO act. Then the case went to the attorney general of the state and he ruled that they had to offer FHP. That was our first big account. There was a lot of pent-up demand there because we signed up five hundred of the state employees right away.

Hughes: What was the second account?

Gumbiner: The second was the University of Utah where we basically did the same thing: presented them with the HMO law, our attorneys wrote them a letter citing what had happened in the state of Utah, and they agreed to offer it. They didn't have a choice. Those two accounts were popular with the employees and they liked the service they were getting so we could then use them as a reference to get other accounts.

Hughes: When the group from FHP moved in, did the existing management move out or was it not as clean as that?

Gumbiner: We kept the existing management. We kept everybody in place. I worked side-by-side with the marketing director who was already in place, but he reported to me. Our medical director worked with their medical director.

Hughes: Was it difficult for people who had been doing a job presumably for many years to learn a new system?

Gumbiner: It was relatively easy because Utah Group Health was going to go out of business and everybody there knew it. They knew that without us they would have no job. So they were happy to have a job.

Hughes: Did most of those people work out?

Gumbiner: Yes. The finance director is still there.

Hughes: So there wasn't a big turnover?

Gumbiner: No. Some people left. The medical director left and went into private practice. The turnover among the doctors and medical directors tends to be a little higher because they are more mobile. They've got more opportunities. The medical director left four or five years later, so I would say, no, we kept most of the people. There was low turnover there. There is low turnover in general in Utah with regard to employment.

Hughes: Why did you leave in 1977?

Gumbiner: I left to go back and complete my MBA because I only did the one year at University of Utah before coming back to FHP. The reason I only completed one year of my MBA initially is because I applied to Berkeley but didn't get in. So then I decided, well, I'll work for a year and reapply to Cal State Long Beach. I got into Long Beach and had to wait until the next semester. That's when I did the work for FHP, selling in California and working in Utah. I don't like to leave anything half-finished, so I left Utah and completed my MBA at Cal State Long Beach.

Hughes: Did your dad teach there at that point?

Gumbiner: He had taught there. He wasn't teaching there when I went there.

Vice President of Marketing, Health Maintenance Life Insurance Company, 1978-1980

Gumbiner: Then I went out and worked for the other HMOs and then I came back to Health Maintenance Life.

Hughes: You became vice president of marketing for Health Maintenance Life in 1978.

Gumbiner: I came back in 1978 to work for Health Maintenance Life. From 1977 to 1978 is when I worked for the other HMOs.

Hughes: In 1980, you became executive vice president of Health Maintenance Life which we have talked a little about. The next year, you became vice president of marketing.

Gumbiner: For FHP.

Hughes: Right. That meant you were here at the corporate headquarters.

Gumbiner: Right.

Hughes: Was that considered a promotion?

Gumbiner: I think it was a lateral. Yes, it could be considered a promotion. When we first started Health Maintenance Life up, we made the mistake of allowing people to sell the insurance program separately from the HMO and we got into a competitive situation. Originally, the idea was that Health Maintenance Life was going to be a companion to the HMO. But then it was selling so well that we decided we would try to sell it on its own, and we did. We sold a lot of business.

But we then got caught by rising hospital costs in both the HMO and Health Maintenance Life in 1980. The hospitals had raised their rates and our expenses went up. The board of directors did not want to continue financing Health Maintenance Life. So we decided we would try to sell the company. The board of directors gave us six months to sell the company. They said, "If you don't find a buyer, we are going to shut it down. We are going to cancel all business."

We negotiated with several different buyers and we had a buyer who was supposed to bring a deposit check in of a million dollars. But he didn't show up. So then we had to cancel all the business. We gave the accounts thirty days notice and we shut down that operation in California and Utah. But we kept it running in Guam because it was profitable there. We kept the company dormant as what they call a shell, a chartered company but with no business in it.

In 1986, we decided to start the company up again. We went out and hired a president. He is the current president, Ed Zutler. However, we learned from our past mistakes. We reorganized the company so that this time we only sell dual choice with the HMO. We renamed it so it would have a better reputation. Since we had shut it down as Health Maintenance Life, we decided we would give it a new name, FHP Life, and tie it more to FHP. Also we decided we would only sell it with FHP, the HMO. We would not sell it on a stand-alone basis. That was a major change in strategy.

Hughes: Why was the company revived?

Gumbiner: It was revived because the market changed and we needed to be able to offer what's called a sole source product--one carrier for both the HMO and the insurance. We embarked on that as a major strategy. We had that as a major strategy initially, but it was premature. We never fully pursued it. We were selling

it and then we branched off and decided to try and sell it on its own, standing alone. It's just too tough to compete as a small insurance company against larger insurance companies.

Plus, insurance per se is a thing of the past because you can't control the costs. So everything is tending to go toward managed care. We sold insurance as a dual choice with the HMO for those few people within a group who want to retain traditional health insurance.

Hughes: And they really were the few?

Gumbiner: Right.

Vice President of Marketing, FHP, 1981-1986

Hughes: What do you care to say about being vice president of marketing for FHP?

Gumbiner: It's challenging. We always have to keep one step ahead of the competition, constantly introducing new products. The biggest new product we introduced, of course, is the Senior Plan. The biggest product we had before that was our Medi-Cal program, but as the state continued to squeeze the amount we were getting paid, that program became less and less viable. We needed something else. Then the Senior Plan came along.

Hughes: Whose idea was that?

Gumbiner: That was a demonstration project that was initially offered by the government, but it was my father's idea to go into it and to go after it. We went after the contract and we got it.

Hughes: How does it differ from Medi-Cal?

Gumbiner: It differs from Medi-Cal because, number one, it is properly funded.

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Gumbiner: Poor people under Medi-Cal have no political power and nobody cares about them, and if they don't get any health care, there are no complaints. So they generally get their benefits cut and nobody does anything about it. But the Medicare program is for everybody over sixty-five including some wealthy, powerful individuals. Whenever Congress or anybody tries to reduce their

benefits, they become very politically active. Therefore, it is properly funded.

Hughes: Was the Senior Plan part of Medicare?

Gumbiner: Right, it's Medicare. It replaces Medicare. But we do the same thing under Medi-Cal. When seniors signed up for our program, we replaced Medi-Cal. Their Medi-Cal card was no longer valid, and they had an FHP card. Under the Senior Plan, it's the same concept. The Medicare card is no longer valid. They have the FHP card instead. Under the Senior Plan the [federal] government pays us 95 percent of what their costs are. But their costs, which are based on fee schedules for doctors in hospitals, are more reasonable than Medicaid because, as I said, if they don't pay doctors enough on Medicare and they stop seeing seniors, there are a lot of political repercussions.

Plus, Medicare makes up a much larger proportion of health care delivery than Medicaid. Medicaid might make up 10 or 15 percent whereas Medicare could make up 40 percent. So doctors in hospitals really can't afford to go without Medicare. They can afford to go without Medicaid.

Hughes: The senior centers were an outgrowth of the Senior Plan, were they not?

Gumbiner: They were the initial way that we delivered the Senior Plan. We designed a special center for seniors with a larger pharmacy, larger walkways, more handicapped access, et cetera, and staffed differently--with internists instead of family practitioners.

However, there was no way we had the capital resources to continue to build centers as fast as the program could grow. That's why we started the IPA in California. The only place we had an IPA up until then was in Guam--HML. When we started FHP Life Insurance Company up again, we transferred all the business on HML in Guam into a new company called HML of Guam. That's what it's called now. It's a separate company.

So for the Senior Plan, we took the IPA concept, which was being utilized over in Guam, under HML, and we transplanted that to San Pedro. We started our first California IPA in San Pedro: the same model, same type of contracts, where the doctors bill against a pool of money that is based on a percentage of the premium, and then their charges are adjusted every month based on the actual utilization.

We went with San Pedro Peninsula Hospital and the doctors on staff there. This was our first IPA. Then the IPAs took off

and started growing with the Senior Plan. We then added commercial business to them and now FHP has more members in IPA plans than it does in staff model plans.

Hughes: So the IPA has been a success?

Gumbiner: Yes, very successful.

Hughes: Have there been troubles concerning control?

Gumbiner: There have been some troubles, but having the staff model capability helps because if we do get into trouble, we can always add a staff model. In fact, that's what happened to us in San Pedro. The hospital canceled its contract and tried to form its own IPA to compete against us. Then we put a staff model into San Pedro. By virtue of having that staff model there, it helped us then negotiate another contract with a competing hospital, Bay Harbor Hospital, with the staff model as part of the plan, and the IPA doctors. That's the plan we have now with Bay Harbor Hospital, and we have our own staff model there. But the majority of the patients are seen by the IPA doctors. The fact that we do have an IPA capability gives us some negotiating leverage.

Senior Vice President, FHP, 1986-present

Hughes: In 1986, you became a senior vice president.

Gumbiner: Right.

Hughes: And associate chief operating officer.

Gumbiner: That occurred in 1992.

Hughes: Do you want to comment?

Gumbiner: I think it was as the company grew bigger, we needed to add more management. We were targeting to keep growing at a 20 percent annual growth rate. We decided that we had to become bigger to survive, that the industry was moving in a direction where you needed a certain amount of size to be able to compete and stay in existence.

To get bigger, we had to hire more management. I needed to hire a vice president of sales and a vice president of marketing. We changed our table of organization to where we had

senior vice presidents and I became the senior vice president of marketing and sales. Then underneath me, I hired a vice president of sales and a vice president of marketing, and I was able to bring in high-level people underneath me to help run the business.

Hughes: You are also a member of the Executive Operating Committee. What is that?

Gumbiner: Yes. In 1986, when I became senior vice president, we had a similar concept--an office of the president. In the original Office of the President, we had myself, Bill Price, and Dave LeSueur. From there we went to an executive management committee where we had Bill Price, Dave LeSueur, myself, and another gentleman, Hal Johnson. That EMC changed over the years with various different members. Just recently, we've replaced the EMC with the Executive Operating Committee.

Hughes: What do these changes mean?

Gumbiner: The Executive Operating Committee is a smaller committee that allows for senior vice presidents underneath it. It's just a way to manage a big business, to have a group of people that can make decisions and not have to rely on just one person to make all the decisions.

Hughes: Each of these forums had at least three people in them.

Gumbiner: Right. They had up to seven.

Hughes: What is the difference between the Office of the President and the Executive Management Committee?

Gumbiner: Well, the Office of the President was prior to Bill Price being appointed president. My father still retained the presidency but he had an office of the president that could help him make decisions. Then, once Bill assumed the presidency, he no longer had an office of the president; we had an executive management committee.

Federal Charges of Diversion of Funds, 1976

Hughes: During the 1970s there were some problems. One of them was the accusation that FHP and several other HMOs were taking federal and state funds intended for Medi-Cal and using them in their profit-making affiliates. There was an investigation by a

Senate committee headed by Senator [Sam] Nunn. Were you involved?

Gumbiner: I was involved in preparing FHP's response in 1976-1977. That was when I was finishing up my MBA at Cal State Long Beach. I took off between semesters to help prepare FHP's response to this investigation. Coincidentally, I worked on preparing that response with Jack Massimino, our current CEO. He was my dad's executive assistant at the time. Jack and I prepared this voluminous response, basically stating that FHP was innocent of all charges and they were totally fabricated. Because of that response that we filed, they never pursued it further because they had no proof. They had no evidence. Everything was strictly based on hearsay.

Hughes: Whose hearsay? How did all this arise?

Gumbiner: Hearsay, just based on reporters. They never could come up with anything concrete. Now, there were other plans, not FHP, that were engaged in wrongdoing, and just because we had a Medi-Cal contract, we got painted with the same brush even though we hadn't done anything wrong.

Hughes: Yet FHP did have profit-making entities.

Gumbiner: Right, but there is nothing wrong with that as long as it is not a conflict of interest and as long as it is a fair deal. We had to, because nobody would loan FHP any money. There was no way to get financing as a nonprofit health maintenance organization, so we had to have ways to get financing to build the business. That was how we did it. The profit-making entities that we had were all used to build the medical centers because if FHP went to the bank as a nonprofit HMO, they said, "We're not going to loan you a dime to build a medical center. You can't get a mortgage." But we would put together limited partnerships with my father as the general partner and myself and others as limited partners where we would pledge our personal assets as partners as part of the collateral to get financing. Therefore, we were able to build the medical centers.

A good many of these medical centers were built with limited partnerships. We would not have been able to build any medical centers otherwise. That was the only way we could get the banks to loan us the money to build the medical centers. To me, there is nothing wrong with that. The government was questioning it and saying, "It just looks wrong. We don't like the way it looks." But they could never find anything wrong with it. After we filed our response, they dropped the whole thing. But we got painted with a lot of bad publicity.

Hughes: There was a suit from the California attorney general's office.

Gumbiner: There was never a suit. Because of the original bad press we got, the attorney general announced that he was going to file a suit but he never filed one. Just because of that we lost our Medi-Cal contract, which was a third of the company's members and about the same amount of revenue. We had to cut back. We tripled the marketing and we cut back on our doctors and our staffing and we were able to sell enough commercial business to make up for it and we were able to survive.

Hughes: What time period?

Gumbiner: That was in 1977, it must have been, that we lost the Medi-Cal contract.

Hughes: My question is, how long did it take to make up your losses?

Gumbiner: It took three or four years. Then we got the Medi-Cal contract back. The state came back to us and said, "Well, nobody wants to treat these people. They can't get health care." Back to the same old problem. "Will you take the contract back?" Which we did.

FHP Foundation

Hughes: What is the FHP Foundation?

Gumbiner: When we converted to for-profit from nonprofit, we had to set up a foundation to receive the net worth of the company.

Hughes: The foundation was set up specifically to receive--?

Gumbiner: To receive the money. The foundation received the equivalent of \$50 million from FHP. They received \$38 million in cash and \$12 million or so in stock--roughly \$50 million. Those are ballpark figures. They use that \$50 million for health care projects. It's nonprofit. They've had various health care projects. They put dispensaries out on the islands, out on Guam, for people who have no access to health care. There are little islands throughout the Pacific where there is not even one doctor, that people live on. We put dispensaries out there with basic drugs and basic medical equipment and a physician-assistant, and a very small dispensary so the people can get some basic health care.

Hughes: Do local people provide the services?

Gumbiner: Right. They would be trained, though.

FHP's Transition to For-Profit Status, 1986

Hughes: Say something more, please, about the transition from nonprofit to for-profit in 1985.

Gumbiner: To build the hospital, we sold bonds as a nonprofit. But the debt market was limited. There was only a certain amount of debt capital that you could raise. To expand and to build more medical centers, hire more people, et cetera, we needed financing and we wanted to be able to access the equity market for financing. We just felt going to for-profit gave us more flexibility to raise money to build the business. It has proven successful because we have been able to do several public offerings and raise money to build the business.

Hughes: Maxicare came into the picture at a crucial moment. Can you tell me that story?

Gumbiner: When we went from nonprofit to for-profit, we were taking a gamble. There were a lot of unknowns out there. It was hard to value the company because it was nonprofit. The equity in the company was much lower than what we paid for it. In valuing a company, the Department of Corporations has to consider the membership, the future potential, et cetera.

Well, Maxicare tried to block us from converting. Maxicare had already gone for-profit. They already had access to the equity markets. They said, "We'll pay \$50 million for FHP." Basically, our price got set by what Maxicare was willing to offer. They just threw out a ridiculous offer just to drive up the price, just like what happened with HealthNet. HealthNet wanted to convert for \$150 million or something and QualMed came in and said, "We'll pay \$300 million for HealthNet." And HealthNet converted for \$300 million.

Hughes: So how did you block Maxicare?

Gumbiner: The Department of Corporations ruled, just as they did in the HealthNet situation, that the purpose is not to change management. The purpose is to arrive at a fair value that will go into the foundation for the taxpayers. They agreed on a fair value. We had several appraisals and we ended up basically

converting for \$50 million. It was close to what Maxicare offered.

The attorney general sued us saying that we didn't pay enough. The basis of our defense was that we were approved by the government. The whole thing was approved every step of the way and we ended up winning the lawsuit.

Hughes: What do you see as the future of FHP with new leadership, your father pretty much retiring?

Gumbiner: I think the company is strong. It's in a good industry. It's got a lot going for it. I would say the future is good.

Hughes: That's to the point. Thank you.

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AN INTERVIEW WITH HAROLD W. JOHNSON, III

Interviews Conducted by
Sally Smith Hughes
in 1992

INTERVIEW HISTORY

Hal Johnson's association of eighteen years with FHP began in 1972 at California State University, Long Beach where Hal was a student in Robert Gumbiner's course on health care delivery systems. It was Dr. Gumbiner's practice to invite his top students to join FHP, and since Hal had gotten an "A" in his class the invitation was extended. Hal accepted and, pro forma, immediately entered FHP's management training program, which exposed recent graduates of business administration programs to all aspects of FHP operations.

After a stint managing one of FHP's medical centers, he was asked by Dr. Gumbiner to become his administrative assistant, the first, and together they developed the role. Johnson must have passed muster for in 1976 Dr. Gumbiner appointed him general manager of FHP's Utah region which opened that year. In 1981 he returned to California as regional vice president, with instructions from Dr. Gumbiner to "fix" the financial problems which the region was undergoing. Again he was successful, and in 1985 became senior vice president with "functional regional responsibilities," terminology stemming from the matrix management system which most of the oral histories describe. In 1990 Johnson retired at the relatively young age of forty-six, discontented with the congestion of southern California and wishing to raise his family in a rural setting.

Mr. Johnson was interviewed by telephone on February 17, 1992 from his retirement home on an island in the Cape Hayes area of Florida. Sounding pleasant and relaxed, he evaluated his long-time associate, Robert Gumbiner, and provided insight into various milestones in FHP history--the early Medi-Cal contract, the first years of the Utah region, FHP's conversion to for-profit status in 1986, and several others.

Sally Smith Hughes
Interviewer/Editor

October 1993
Regional Oral History Office
The Bancroft Library
University of California
Berkeley, California



Harold W. Johnson III, 1990

BIOGRAPHICAL INFORMATION

(Please write clearly. Use black ink.)

Your full name HAROLD W. JOHNSON III

Date of birth 4/28/44 Birthplace LOUISVILLE Ky

Father's full name HAROLD W. JOHNSON JR

Occupation RETIRED PLANT MGR Birthplace DETROIT MI

Mother's full name DORA E. HATCHER JOHNSON

Occupation HOMEMAKER Birthplace CORBIN Ky

Your spouse LINDA A. JOHNSON

Your children HEATHER WENDY JOHNSON

DREW COLIN JOHNSON

Where did you grow up? MOMENCE ILL

Present community PLACIDA FL.

Education BS, MS

Occupation(s) MGMT

Areas of expertise GEN MGMT

Other interests or activities CHARITIES, SKIING, FISHING, SAILING

SCUBA, GOLF, RAISING MY CHILDREN

Organizations in which you are active NONE - RETIRED

VII AN INTERVIEW WITH HAROLD W. JOHNSON, III

Background

[Date of Interview: February 17, 1992, by telephone to Johnson's home in Cape Hayes, Florida]

Hughes: Mr. Johnson, could you tell me where you were born and educated?

Johnson: I was born in Louisville, Kentucky, in 1944. I grew up in Illinois and went into the Air Force during Vietnam. When I got out of the service I went to El Camino Junior College and then California State, Long Beach for my bachelor's and master's degrees.

Hughes: And I understand there you were a student of Dr. Gumbiner's.

Johnson: Right, that's how I met him. He was teaching an elective class; I think it was called Health Care Delivery Systems.

Hughes: Tell me about him as a teacher.

Johnson: It was interesting. When I took the class, I knew nothing about him, didn't know who he was, and had no real active interest in health care. It was an elective and it seemed like it fit into my schedule, so I took it. There were seventeen graduate students in the class, and he arrived about twenty minutes late for the first class. Everybody was ready to leave when he walked in with a recent graduate, who was helping with the class.

He immediately starting saying things like, "Well, we're going to have a case study every week and you're going to have to identify the problem and give me the solution on one page, eight-and-a-half by eleven inches." Everybody looked at each other and said, "What is this? Who is this guy?" [laughter]

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Johnson: It was interesting. When I took the class, I knew nothing about him, didn't know who he was, and had no real active interest in health care. It was an elective and it seemed like it fit into my schedule, so I took it. There were seventeen graduate students in the class, and he arrived about twenty minutes late for the first class. Everybody was ready to leave when he walked in with a recent graduate, who was helping with the class.

He immediately starting saying things like, "Well, we're going to have a case study every week and you're going to have to identify the problem and give me the solution on one page, eight-and-a-half by eleven inches." Everybody looked at each other and said, "What is this? Who is this guy?" [laughter]

Then he started talking about the history of the HMO concept, with [Group Health of] Puget Sound and Kaiser and the others, working through the development of that mode of health care delivery, and turning it to the course. After the first session he had a case study that he handed out. When we came back to class the next week and handed in the results, he looked at the number of pages turned in. If you had more than one page, he tore them up and handed them back.

Hughes: Because he told you the assignment was to write one page.

Johnson: Yes, and he said in business you don't have time to say, "What if, what if, what if, what if--." You have to identify the problem as you see it and try to come up with a solution. He was very direct. [laughter] Several people wanted to blow up his car. [laughter] It was interesting because the class gave me a little insight into the people that worked for him, that I wouldn't otherwise have had. He does love to teach. I don't know if he admits it or not, but I think that any chance he gets, he tries to teach, and you can learn a lot from him. A lot of people have.

Hughes: Was it an interactive style of teaching?

Johnson: It was not didactic, one-way. It was much more interactive than perhaps some of the students wanted it to be.

Hughes: They would have preferred to have him tell them things.

Johnson: Yes. But in that particular course at Cal State Long Beach, he worked very heavily from the case studies and tried to get people to think and determine what were important facts and what weren't, and read between the lines. It was very helpful.

Hughes: Was the HMO concept familiar to you when you started?

Johnson: No, I had had no contact with health care at all. It was just something that I fell into serendipitously.

Joining FHP, 1972

Hughes: How did you come to join FHP?

Johnson: After graduation, I went back to Illinois where I had grown up for interviews with General Foods and General Mills. When I got back to my apartment in California, my mailbox was stuffed with

telegrams from Dr. Gumbiner. "Come see me about a job." I thought, "Well, I don't know about health care." The offers I had from General Foods and General Mills were with big companies and with a master's degree I would have supervisory positions in a production line or something like that. I thought, "Well, maybe I'll go talk to him." I had a very pleasant interview with him in his office, and he made a job offer to me which was extremely low, I thought, which I found later to be normal practice. After the interview, I told my wife that I was going to work for Dr. Gumbiner at a lot less than the offers I had in Illinois. She thought I was crazy.

Hughes: Why did you make the decision?

Johnson: Because I thought with him, or within that type of small company, I could be a name and not a number. That weighed very heavily on my decision.

Hughes: Is that the way he presented the offer to you?

Johnson: No, that wasn't part of the discussion. He presented it as an opportunity to learn in a staff management training program that he had just recently started.

Hughes: He has written at least one article on interviewing physicians.¹ Were you aware during the interview that he was using unusual interviewing techniques?

Johnson: I'm not sure he did in my interview, because we knew each other. He was just very cordial, not a typical RG [Robert Gumbiner] interview, believe me. [laughter]

Hughes: Why did he want you?

Johnson: I don't know. I got an "A" in his class. Maybe that was it.

Hughes: I'm sure that made a difference. [laughter] Were any of your classmates recruited?

Johnson: Two of us got job offers and started working for him. I think he knew what he was looking for; he knew he had to develop some management. He was using the class as a mechanism of screening people before he had to make a decision on whether or not to hire. Which is smart.

¹Robert Gumbiner. How I interview would-be associates. Medical Economics, September 6, 1965.

There was a big battle with an instructor named Bob Smith, who was in the management department in Cal State Long Beach at the time. Smith wanted to teach the health care courses.

Hughes: Did he have a background in the field?

Johnson: Not really. Dr. Gumbiner was doing it for a dollar a year, or something like that. That made Smith upset, too. Dr. Gumbiner is a very strong individual, as I'm sure you know by now.

Hughes: Yes.

Johnson: And the two of them got toe-to-toe a couple times. Dr. Gumbiner's attitude was, "I don't care about him; I just want to teach this program."

Hughes: Is it common in business school to get outsiders to teach?

Johnson: I think it's done more frequently now than it was done back then. At that time, there wasn't a lot of it. There were a few businessmen who were brought in, but more on a full-time basis as opposed to what I think he called an adjunct professor position.

Staff Management Training Program

Hughes: What were you hired to do?

Johnson: I was hired into FHP's staff management training program that he developed. The program takes recently graduated MBAs and runs them through the mill. I ended up doing a little bit of everything and getting a good background in the operation of business. If you can afford the time and money that it costs to do that, it's probably the best way to prepare somebody for running a portion of the business.

Hughes: But because of the time and money, a lot of concerns don't do it that way?

Johnson: Well, I don't know of many that do. At the time I was in the staff management training program, it was a two-year program. The company is paying a managerial salary for two years and is maybe getting some benefit from it, but certainly not a full-blown management effort. So that's quite an investment.

Hughes: The training program was very much Dr. Gumbiner's idea, wasn't it?

- Johnson: Oh, yes. It ties in with his real interest in teaching, educating and developing people, as well as his clear understanding of the need to develop management to grow the company.
- Hughes: Also, as I understand it, his philosophy is that medicine is business and should be run by business principles.
- Johnson: Right, absolutely.
- Hughes: He seems to have rather a scathing view of medicine.
- Johnson: Well, over the years if you spend much time with him, you tend to develop one yourself. I have to be careful because my brother-in-law is a vascular surgeon. [laughter]
- Hughes: After you had had this two-year training program, what happened next?

Assistant to Dr. Gumbiner, 1974-1976

- Johnson: During the training program you work in variety of areas. One of the areas that I ended up spending more time in was center management, actually managing a medical center. Then Dr. Gumbiner decided he decided that he needed to have an administrative assistant, somebody to work directly for him, to run errands and whatever. He asked me to be his administrative assistant, which was the first one he'd ever had. I'm not sure in hindsight why I did it, but it was a great opportunity to help develop that role. He didn't know either what he wanted from it. So we circled for many months, trying to figure out what the relationship should be, what the responsibilities should be, and things he didn't want to do.
- Hughes: That you did?
- Johnson: Yes. Which was fine. I once had to terminate a facilities director who reported to him, because he didn't like him. I happened to like the guy, and that was tough.
- Hughes: Did you come to an understanding of what your responsibilities were as distinct from his?
- Johnson: I think so, within six months. Over time it became fascinating to me. It was certainly an opportunity to see the organization

from the top and through his eyes, which was invaluable to me later on in my career in the company.

Hughes: Can you say something about what he was like as an administrator and a manager?

Johnson: In looking back over the eighteen years that I spent with him, I'd have to classify him as not necessarily a dictator--but close--in his managerial style, very tough. It worked for him, and he could pull it off because he had the presence and drive to cause people to build a respect for him. Whether they liked him or not, they respected him. It was almost a reverence at times. He was usually very abrupt and cool to people. He just didn't care to try to develop relationships.

Hughes: I should think at times that would work against him.

Johnson: It can, and probably did. It would tend to cause you to get into a conflict more often than not. But he really didn't care.

Hughes: Would he listen to and sometimes act on opposing viewpoints?

Johnson: I don't know whether he would admit it or not, but he would always listen. When I was in the administrative assistant role or in other positions later on, I found that if you threw out an idea to him, he would immediately throw it back saying, "No, it won't work." Then in the middle of the night you'd get a phone call from him saying, "I just had a blinding flash. Let's do it this way." And you'd think, "Boy, that really sounds familiar." You'd say, "That's a great idea." [laughter]

Hughes: He knew it was your idea, did he not?

Johnson: Oh, I'm sure. And that's fine. It's the way he was.

Hughes: Well, that wouldn't be fine with some people.

Johnson: No, and I think that's why over the years there's been a fairly high turnover in certain management positions.

Hughes: Another thing I would think that would be hard to emulate was his sheer energy.

Johnson: Well, you didn't sit back and smell the roses.

Hughes: Everything has to be done yesterday.

Johnson: Yes. You know, he has a philosophy on getting things done. He's often told the story of, "If you waited for the 747, you never

would have gotten an airplane off the ground. You had to put a DC-3 out there first to make sure you got it flying, and then you develop it." That was really his philosophy to a great extent in developing medical facilities. You don't build a 20,000-square-foot medical facility. You build a smaller modular unit and stick it in the area where you think it might work. Then if the area proves itself, then you build a larger permanent building. He's talked about that over and over again in various presentations to managers and doctors. Most of his philosophies or theories he tends to live by. It makes him somewhat predictable.

Hughes: Could you characterize your relationship?

Johnson: It vacillated from very good to very bad over the years. After I was in the administrative assistant position a while, he came to me and said, "I want you to go to Guam and run the Guam region. The person that's there has to come back now."

Hughes: What year was that?

Johnson: That must have been about '74.

Hughes: So right after the program started in 1973.

Johnson: Yes, it had been operating about a year and one-half and it was about time for the other person to rotate back after two years.

Hughes: So you moved from being administrative assistant to Guam?

Johnson: No, I turned him down. He asked me three times, and I didn't know whether it was a career decision or not, to turn him down. [laughter] I had spent some time in Okinawa during the service, and I decided I didn't want to live on an island. He never really said much other than, "I want you to go." I said, "No, I'm not going to go." About two or three months later we put together the Utah region--it was late '75--and he said, "I want you to go to Utah and run that."

Hughes: He kept turning to you. What did he see in you?

Johnson: I don't know. [laughter]

Hughes: Oh, you must have some inkling.

Johnson: Well, I think my time as administrative assistant was a critical point for me, because it gave him an opportunity to evaluate me. I became a known commodity. Whether it was good or bad, it was

something that he knew. He probably didn't have too many choices at that point.

FHP in Utah, 1976

Johnson: Anyway, he asked me and I decided that I had better not turn him down again, so my wife and I moved to Utah.

Hughes: Tell me about Utah.

Johnson: Dr. Gumbiner's approach to expansion is really quite varied and I think fascinating. For example, with the Utah situation, for several years Dr. Gumbiner had asked a former FHP board member, who had gone to Utah and was teaching in the university system up there, to keep an eye on the marketplace. He wanted him to watch a couple fledgling attempts at starting a prepaid health care program there. Carmen Ness was his name. He was a Ph.D. who was teaching in Utah.

Carmen called up and said, "The Utah Group Health Plan is having some difficulty. It might be a good time to talk to them." So Dr. Gumbiner went to Utah and started some discussions with Irene Sweeney, who is still on FHP's board, who was then chairman of the Utah Group Health Plan board, and Diane Moeller, who was the executive director there. Diane Moeller was an interesting lady, a very sharp manager and business person, who realized that without some significant support financially and managerially, their organization probably would not make it. They saw FHP as an opportunity to give an infusion of financial aid as well as some management experience to help them over the rocky part of developing an HMO. So FHP actually negotiated a management contract leading to a merger. It was a six-month management contract stipulating that if we met certain objectives then FHP could enact a merger of the two entities, which is what occurred.

Hughes: Did FHP take over the operation with the existing personnel in place?

Johnson: Partially. They were a group practice model, and RG wanted it to be a staff model where the doctors were actually salaried employees of FHP.

Hughes: Why did he insist on that?

Johnson: Well, it gives you much better control, and in a group setting you're always negotiating with the doctors as a group. Groups really don't have the controls that you need from a standpoint of systems and quality.

Hughes: Was that ever a stumbling block to recruiting physicians?

Johnson: Oh, it is, and it has been. It's not so much now; I think it's much easier to recruit physicians to an HMO today than it was fifteen years ago.

Hughes: But in the old days a doctor would be resistant to the idea of being an employee of anyone.

Johnson: Well, about 90 percent of these doctors were. They didn't want to see it happen, and they refused to sign their individual contracts that had to be in place by January 1. In fact, instead of having a New Year's Eve party I was calling people at New Year's Eve parties, telling them if they didn't give me a verbal [agreement], we were going to have a doctor come from California to take their place next Monday.

Hughes: Did you really have those doctors?

Johnson: Well, we had maybe one or two.

Hughes: [laughter] How many signed?

Johnson: All but one signed.

Hughes: What changed their minds?

Johnson: They didn't have any option, really. HMO patients were a majority of their practice. So if they didn't have a job, they'd have to start over again in building a practice. Now what happened was, over time, most of them ended up leaving. But they stayed long enough for us to recruit physicians to that unit. There are one or two that are still there, though.

Hughes: Do you think they left primarily because it was a staff model as opposed to a group model?

Johnson: Probably that, and there was significant pressure from their peers to not join the "enemy."

Hughes: Had there been similar problems once a physician was recruited to FHP in California?

Johnson: There were occasionally, but not as many because, first of all, they were not forced into a situation like that. They elected to join FHP as a physician. They pretty well knew what they were getting into. Some physicians right out of school would use FHP as a great way of building a nest egg until they went out and bought a practice.

Hughes: Does FHP approve of that practice?

Johnson: Well, no, but you can't stop it. What you try to do is screen for that in your recruiting process, but you're not going to catch that very often. In many cases, they don't leave. They may get very comfortable with FHP and feel that they are doing well. We've had some physicians that left and came back. They said it's much tougher out there in the real world than it is here, and they're happier here. Even my vascular surgeon brother-in-law admits in a weak moment that working for an HMO may not be a bad deal, because then you don't have to worry about all the office problems--hiring, salary, the receptionist--.

Hughes: And the malpractice, et cetera.

Johnson: And all that, yes. So that's part of the recruiting song.
[laughter]

Hughes: Other than this physician problem, were there other major problems that you faced in Utah?

Johnson: We had to accomplish about six or seven major milestones simultaneously within a few-month period to get it on the right track in order to make it successful. One is we had to introduce the existing employees to new operating systems. There was a four-person team that went up there. Burke Gumbiner was sales manager. Dr. Del Stokesbary was a physician who became medical director. He was an older physician who had been with the company for many years. Diane Ystrom came up as an operations manager. Burke had been in sales in California, and Diane had been in operations in California, and Del had been working as a doctor and had been medical director in Guam.

Hughes: Who chose those people?

Johnson: Dr. Gumbiner.

So he sent the four of us up there, none of us with reams of experience, and said, "Go do it!" He checked with us frequently, obviously. He came up frequently in the early stages to make sure that the direction was understood and that we were on the right track.

Hughes: Do you want to say more about Utah?¹

Johnson: Well, just to say that in Utah, it was an opportunity for FHP to really test its systems in a new entity. FHP through Dr. Gumbiner had become a very systematized organization in things like the placement of the exam table in the exam room and what goes in the drawers of an exam table. It was all documented, written down, had to be adhered to. A lot of it was based on motion-time studies, things that he had done personally or had people do early on, trying to save doctor time. Doctor time was money. In transplanting those systems to Utah it took a bit of an educational program and battle to try to get people to use new systems that they hadn't been involved in developing. But over time it worked.

Dr. Gumbiner's approach in Utah was not to take a slow, methodical approach of getting the businesses, one group at a time. He needed a big block of business to carry the fixed overhead and the ongoing flow of money. We had to go after the state and university employee groups. We found that there was enabling legislature in the Utah HMO law that allowed us to mandate the state and university and some of the school districts, if some of their employees wanted to have an HMO. The way it read was, "a few employees." It got to the point where we were being denied by the state attorney general. We had to go to the ex-governor, Calvin Rampton. We were being stonewalled by the attorney general to whom the state personnel department had thrown the issue.

Hughes: Why did he stonewall?

Johnson: At the time we had no idea why, because it was logical to us. We finally had some pressure placed on him and he said, "Well, we'll look in a dictionary."

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Johnson: He came up with a definition [for 'few'] of two or more, and he said, "Okay, fine. I'll approve the contract." What we found out was (at least from my recollection) that his wife was on the local board of directors of Beneficial, or one of the other large insurance carriers that happened to have the state contract. [laughter] Whether there was a connection or not, I don't know, but sometimes you speculate. So, we were able to get the state and university contracts, and they really became the cornerstone

¹The following discussion of Utah occurred later in the interview and was moved for better chronology.

of business for FHP there in Utah, and it's grown from that. It was fun.

Hughes: Had there been a philosophical shift? Or was it circumstance that had confined FHP to southern California and Guam in the early years?

Johnson: I think to a certain extent it was just concentration on surviving. There was fierce competition by fee-for-service and other HMOs. It was in the early stages of the HMO concept, when it was difficult to sell to doctors and it was difficult to sell to members. We had Kaiser in our backyard, which was a dominant force, plus Ross-Loos and HMO International.

Hughes: Was FHP making any attempt to attract a different sort of clientele than Kaiser and the other HMOs?

Johnson: Not really, in that they all were going after the employer market.

Medi-Cal

Johnson: FHP was also contracting with the state for Medi-Cal. But that became a program that was a double-edged sword. It provided a good revenue stream, but it also was not looked on with favor among some of the employers, who didn't want their employees being seen in the same medical center with Medi-Cal. That was something you had sell around as well.

Hughes: There were problems, as you well know, with the Medi-Cal contract. There were charges in 1976 that federal and state funds were being diverted by FHP and four other HMOs into for-profit affiliates.

Johnson: Oh, yes, that was with Sam Nunn?

Hughes: Yes.

Johnson: The Star Chamber. [laughter]

Hughes: Did you have direct contact with that problem?

Johnson: I was in Utah then, but I certainly heard a lot about it, but it was more thirdhand.

Hughes: Was there any substance to the charges?

Johnson: I don't think so. When you have a nonprofit company and you're trying to get started, you have to go to other people to get money to buy equipment, and then you lease it from them. You don't have the money to go out and buy it. The bank's not going to loan you money. And so in the beginning of FHP nonprofit there had to be some investor groups developed to buy buildings and be willing to rent to the company. A lot of those were still in place at the time that those allegations took place. Nothing was proven wrong, that I know of, and there were no real problems that came out of it, other than it made a nasty Christmas holiday for several people.

Hughes: Also, the Medi-Cal contract was dropped for a period.

Johnson: Right. And then they came back and asked us to take it back.

Hughes: I understand that at that point the Medi-Cal contract counted for about one-third of FHP's business.

Johnson: Right.

Hughes: What happened when that business dropped out?

Johnson: It was traumatic. That's the type of thing that no one wants to see, but I think that FHP was probably better prepared to handle it than other firms because of Dr. Gumbiner's philosophy in taking direct action and not sitting back and thinking about it a lot. You have to react quickly to a situation like that, and you have to carve staff out, and it hurts. No one likes to do it, but you have to save the company.

Hughes: What did he do, specifically?

Johnson: Well, sitting back in Utah and watching the trauma was a little bit easier than being a part of it, because the Utah unit was pretty much unscathed by the needed cutbacks, because it was more a California problem. But there was a reduction in staff and a tightening of the belt to weather the drop in revenue, but also a very heavy emphasis simultaneously placed on sales, marketing, and advertising to backfill.

Hughes: How does Dr. Gumbiner react in a crisis?

Johnson: To me, he's actually better in a crisis than he is in a lull. If it becomes too routine, he becomes bored and somewhat unhappy. I think he'd rather have a crisis, maybe not one of that magnitude, [laughter] but something demanding to be doing.

Hughes: I have the distinct impression that he relishes a good fight.

Johnson: He does. I wouldn't say he goes out of his way to pick a fight, but sometimes you wonder. He sets a direction, he knows how he wants to achieve something or where he wants to go, and he doesn't want anybody getting in the way.

Hughes: Do you have any insight into why he is this way?

Johnson: No, except it seems like he's always been that way. But I really don't know if it was innate or whether something happened early on that caused that. It's always been my personal belief that at some point he was very close to somebody and was let down or betrayed. I've seen many times that he has this shield that he carries out in front of him, and he doesn't let people get close to him. Although, at times that shield seems to drop, and there's a very warm, very caring person there, which, when you see it, you say, "Wow!" I don't know beyond that, my curbside psychiatry.

Hughes: When and why did you leave Utah?

Johnson: After a year and one-half Dr. Gumbiner came to me and said, "I want you to stay another year." I said, "No, I want to come back because the organization is growing very rapidly, and I'm going to get left out." I felt isolated from the development of the organization as a whole. We were skiing in Park City, and the chair lift broke down; he was stuck, he couldn't get away from me. So he had to talk to me. [laughter] I convinced him that I was going to come back. So I came back to vice president of operations.

I bounced around frequently in the next three to four years after that. Operations really wasn't the corporate position as it is today. At that time the operations responsibilities were very confusing and mixed between California and corporate. Everybody was housed in the same building. You didn't really know who was running what. It was sort of a blend, which later was straightened out. But at that point operations had the responsibility for the medical centers, nurses, lab x-ray, and things like that.

Hughes: You mean everywhere?

Johnson: That's pretty much the way it was set up, yes.

Matrix Management System

Johnson: At that time also, Dr. Gumbiner was in the process of introducing his matrix. He was starting to develop the concept while I was still his administrative assistant. In fact, I had an opportunity to travel with him to several seminars on matrix management. We would go to these courses, and then we would sit in the hotel room in the evening and hash over what we had heard and how it would apply to the company. From that he developed his plan for matrix in FHP. I'm trying to remember exactly when it was introduced. It was in place until about a year or so ago.

Hughes: When he retired?

Johnson: Yes.

Hughes: Can you tell me what it is in a nutshell?

Johnson: Well, the concept is that you have really two lines of managers, one at the corporate level, which are called the functional managers. You have a functional manager for operations or for marketing or for medical. These are the people and their staff who have the greatest knowledge and experience in that particular area.

Then you have somebody, say an operations manager in the California region, that has similar experience but perhaps not as in-depth, who is responsible for the medical centers, labs, and nursing there. Operations managers have the direct responsibility of day-to-day operations in the California region. The VP of operations at corporate would have an overview responsibility, making sure that all the systems are the same in each of the regions and that the operations are working smoothly in each of the regions.

The operations manager in the California region would report to the vice president of the California region and to the vice president of operations at corporate. So you have a dual line of reporting, which is the matrix. But there was a lot of fighting because people were frightened by it. There was a fear of mixed messages, mixed directions, confusion.

Hughes: Did that happen?

Johnson: It happened. Actually, not as frequently as I thought it would.

Hughes: You had some doubts, then, about this system?

Johnson: Well, initially I think everybody did. But if you want matrix to work, you can make it work.

Hughes: Where had it worked before?

Johnson: They'd used it in aerospace, where they had limited resources of high-level knowledge in certain technical areas, and they had to spread it over many projects.

Hughes: Do you think that's where Dr. Gumbiner got the concept?

Johnson: That's one of the areas that he had studied.

Matrix worked well for the company during the time of rapid growth. FHP just didn't have enough trained people to have a well-seasoned operations manager for each region.

Hughes: Has matrix recently been dropped because there now is a seasoned group of managers?

Johnson: I really don't know. It's a very cumbersome, very costly management structure. It gives you flexibility to the extreme. I think it did well for the company during that rapid growth phase. Although the company is still growing very rapidly, it appears that they're using a different approach at this point.

Independent Practice Associations

Hughes: FHP expanded to Arizona and New Mexico in 1985.

Johnson: Yes. FHP went in there as an IPA, which was something new to the company.

Hughes: Yes. Why?

Johnson: I think it was more of an experiment than anything. It was an opportunity to see if we could make an IPA fly.

Hughes: If Dr. Gumbiner had always been an advocate of the staff model, this seems to be taking a real leap.

Johnson: Well, it is. In fact, I'm not too sure he didn't have a bet with somebody that it wouldn't work. [laughter]

I think that it was truly an experiment, and that if you ask him today, he'd still tell you that staff model is best. I think

he may say the IPA may have a place, but always have a staff model embedded in it. The theory is that you have the staff model to fall back on. If the IPA doctors start getting real nasty and say they are going to hold you up for higher fees or whatever, you can tell them, "Goodbye. We'll take your patients and put them in our staff model."

Hughes: Is there a staff model in those states?

Johnson: Well, they have medical centers, so, yes, there is.

Hughes: FHP has used the IPA much more frequently in California in recent years.

Johnson: Right. Again, I'll think you'll find that in most of those areas there are plans or probably will be plans to put staff models in at some point. It's a philosophy I happen to believe in because I've seen other firms that are IPA only come apart at the seams when the doctors get unruly.

Hughes: Is the hope that the IPA physicians will be converted to the staff model?

Johnson: Not necessarily, no. I think what it does is builds a volume. If you can prove the marketplace, particularly in a new area like Arizona or New Mexico, and then based on how receptive the marketplace is to the concept, you can make your hard-dollar investment to a physical plant and equipment alongside and in support of the IPA.

Hughes: When FHP was contemplating moving into a new area, how was the assessment made that the plan had some potential of success?

Johnson: A fairly intensive evaluation was done in most situations. In fact, at one time I was a VP of corporate development, and I was responsible for mergers and acquisitions. We would go out and research areas. I went to Madison, Wisconsin. There was a staff model there that was having difficulty. I thought it would be a repeat of Utah.

Hughes: And it turned out not to be?

Johnson: Well, it could have been, I still believe. But we packaged it and then gave it to Dr. Gumbiner. I had their board executive committee ready to enter discussions and Dr. Gumbiner said, "I don't like it. You have to change planes to get there."
[laughter]

Hughes: That surely wasn't his only reason.

Johnson: No, probably not. But occasionally he would say, "I don't want to go too far, because I don't like long plane rides." It had to feel right to him. If it felt right to him, then it would be fine. He's not totally predictable in that.

Hughes: That must have been difficult for people like you to work with.

Johnson: Oh, it kept you guessing. [laughter] Actually, I think it made it fun. Certainly there were bad times and frustrating times in the eighteen years there, but there were a lot of good times, too.

Hughes: It doesn't sound as though it was boring, that's for sure.

Johnson: I'll guarantee you that.

Regional Vice President, California Region, 1981-1987

Hughes: What came next, according to my list anyway, is that you became regional vice president of the California region.

Johnson: Right.

Hughes: How did that transition occur?

Johnson: At that time, the California region was having some financial difficulties, and Dr. Gumbiner said, "Go fix them." So I went in as regional VP; he fired the guy who was there. Actually, he claims I fired him, but I don't think that's true. We still argue about who did the actual firing. I started working on developing some of the existing managers into higher positions with more responsibility, basically strengthening the region and getting it back on track. One of the things that I found when I got there was that most of the managers there didn't know there was a problem. I've always been a believer if there's a problem, everybody's going to know about it.

Hughes: Was that the fault of management?

Johnson: That was the fault of the person that was I was replacing. He was hoping it would go away, I think.

Hughes: What did you have to do?

Johnson: Well, we had to tighten the belt, cut out some of the niceties that had been built into people's budgets, and get the region

back to hard-line, no-nonsense business. Which doesn't happen overnight. But we got it back on track and it became successful.

Hughes: Did you find through all these career changes that you were undergoing that your background in business, and specifically what you had learned in the MBA program with Dr. Gumbiner, was serving you well?

Johnson: I think that the experience in working for him directly in my early years in FHP was probably ten times more important than what I learned in school. I've got a master's, but to me, it is the experience that counts. When I used to interview managers, whether it be for the staff manager training program or for managerial positions I was trying to fill, I wanted them to have a degree but it didn't really matter what degree. It was really what was in the person and his attitude towards doing things that were most important. The experience, I felt, we could give them. They needed to have the right attitude and the willingness to go out and do something. To a certain extent I think that was Dr. Gumbiner's philosophy that I picked up.

Hughes: Learn by doing.

Johnson: Yes. He gives you the opportunity to do that, and lets you make a mistake, too--once. [laughter] Learn from your mistake or forget it.

An interesting situation: we'd had a contract with a hospital in Long Beach about the time that we were getting ready to take over a hospital. We had an opportunity to give notice of cancellation of the existing contract about the time we were starting the one we were taking over. I missed that window of opportunity, so we were stuck with that hospital for a couple more years, and that meant we had two hospitals but not enough patients. So it was a major error and certainly not something I would miss again, but I did then.

I'll never forget, a couple days later Dr. Gumbiner sat across the table from me and looked me in the eye and said, "If you were an attorney, I'd fire your ass!" After that I got promoted, so I can't figure that out. [laughter] I really think that he is not intolerant; he just expects you not to make a mistake. But if you do, certainly learn from it. I think that's probably not a bad philosophy.

Senior Vice President with Functional Regional Responsibilities,
1985-1990

Hughes: Your last position with FHP was senior vice president with functional regional responsibilities.

Johnson: That was again while the matrix was in place. We had the Executive Management Committee at that time that had four or five senior VPs. Each of us had a portion of the business and those responsibilities rotated each year. So I had regions and I had functions. Sometimes there was a mix. You may have one or two regions and a couple of functions.

Hughes: Is it unusual to rotate?

Johnson: It probably is, particularly on an annual basis. That's fairly quick. You just get up to speed and then you're changing again. But on the other hand, I think Dr. Gumbiner was trying to do several things. One was to see who he had, what they were capable of, and whom he should be targeting for future moves up, as well as really getting some depth and backup. If somebody falls out, then somebody else can step in and field it until you get a replacement.

Hughes: On the other hand, I would think that the drawback would be the dead period when somebody was learning a new job.

Johnson: Except most everybody in those roles had been in those roles within a region and so forth. So it wasn't really all new, it was just learning the lines of communication.

The thing I liked most about that time was the Executive Management Committee. It was a real good group of people that really worked well together. It was a very diverse group. We went into the meeting with diverse opinions and positions, but we never left the meeting without having had an opportunity to air them and come to an accord. I think the two or three years that we were in that role were just the best years. The company was not without problems then; we were growing, we had growth problems, and we had other types of problems, but that group of people was special.

Hughes: What years are you talking about?

Johnson: I left in 90, so it would be the fiscal years ending 90, 89, and 88. Those are the times that I like to remember. It was a lot of fun.

FHP's Conversion to For-Profit Status, 1986

Hughes: Well, then there's the conversion from nonprofit to for-profit, which you must have been involved with.

Johnson: Right. That was yet another major milestone for the company. Had that conversion not been successful, the company would not have been able to grow to the size it is today. It was traumatic at that time; there were a lot of attempts made to try and prevent it going for-profit. I think Maxicare was involved in trying to prevent that.

Hughes: Tell me about that.

Johnson: My recollection is that FHP had to file with the attorney general [AG]. At that time FHP was a nonprofit organization and it came under the AG. You had to negotiate with the attorney general a price that the investors of the for-profit would buy the assets of FHP, the nonprofit, for. The price had to be fair market value. I think the price had been negotiated with the AG.

At that point Maxicare said it should be a bid process; the asset should go to the highest bidder. FHP for-profit would be in a position of perhaps potentially losing the assets of FHP nonprofit in a bid situation. So there was a lot of legal finagling and arguing and carrying on. Finally the courts said that it was not a bid process, and that the AG had the right to negotiate the price. So then the conversion went forward and FHP became a privately-held company. Then I think it was a year or so later when it became a public company [1986].

Hughes: Could you summarize the reasons why the decision was made to go for-profit at that particular time?

Johnson: Dr. Gumbiner had always said that the advantage of the nonprofit is that you don't have to pay the taxes. Those monies can be turned right around to build up the company--building new buildings, buying new equipment, and growing. Which is absolutely true. But all that self-generated revenue or monies has to be earned. So you can only grow at a certain rate, whereas with a for-profit and public company you do a stock offering and you can bring in large amounts of money and grow much more quickly, if you wish. I think the reason for the decision at that time was that there was a lot of growth taking place and a lot of competition. There were a lot of for-profit public companies that were in the business then, and growing quite rapidly, perhaps faster than FHP could.

- Hughes: So it was a matter of keeping up with the competition.
- Johnson: I think it was a matter of remaining competitive in a rapidly growing marketplace.
- Hughes: Was there any opposition to the conversion within FHP?
- Johnson: Very little that I can remember. There may have been, maybe amongst some of the doctors. There may have been a fear of, that if you go for-profit then the quality motive becomes second to profit. There was some fear, I'm sure. But FHP had always been operated like a for-profit company, even as a nonprofit. The difference is the definition of what the excess revenues are. It's either profit or excess revenues. But FHP had always operated with a desire to have black at the bottom line.
- Hughes: Are you implying that other HMOs don't necessarily operate that way?
- Johnson: I don't know. I think most HMOs today of any size are for-profit.
- Hughes: Well, Kaiser's not for-profit.
- Johnson: That's probably one of the few that's not. Let's see, Puget Sound is nonprofit. I think that in FHP's situation, there had to be a change [to for-profit].
- Hughes: Are there a series of milestones in FHP's history?

FHP University

- Johnson: Well, I think that the major developmental point for the company revolves around Dr. Gumbiner's managerial programs. He had a middle management training program that he participated in developing--the doctor management training program, "FHP University" in conjunction with UCI [University of California, Irvine].
- Hughes: "FHP University"?
- Johnson: Yes. We called it that, but it's really a series of courses that are team-taught with the faculty at UCI. These are things that most companies don't do. It gets back to his major tenet, "If you've got good managers, you'll get where you want to go." So

he's been willing over the years to put the effort and the money into trying to have that happen.

Hughes: Because of this emphasis on management, was there ever a danger of the medical side being short-shifted?

Johnson: No, I don't think so, because his emphasis on management included the physicians. The strength of the management ranks within the physicians is critical. They're a major component of the business.

The interesting thing about medical managers is there are not a lot of them around. Most physicians are just not trained at all in any of the concepts of business or management. I don't think my brother-in-law, a physician, has ever seen his checkbook. [laughter] I don't think my sister lets him have it.

Hughes: Probably very wise.

Johnson: I think Dr. Gumbiner recognized the need for having medical managers. Many physicians today don't want to "report" to a non-M.D. It's just the way they're brought up, I guess. But in many cases, I think even some of our medical managers initially have problems in reporting to a nonmedical person. I'd have physicians reporting to me in management roles, and my first point in our discussions would be, "I'm not a doctor. I'm not going to try to be a doctor. You're the doctor. We'll sit down and talk about where we disagree."

Hughes: And that strategy generally worked?

Johnson: Yes. We had some good people that were willing to try.

Hughes: Is there an FHP physician "type"?

Johnson: Yes. They have to have a good head on their shoulders. They have to be willing to get above the dogma of the old boys' system of doctors. Less so today; I think [the HMO concept] is more accepted today. But back then, you had to be willing to try something different. Physicians came to us for a variety of reasons. Just like the physicians and the people that go to Guam go there for a variety of reasons, and stay there. I think that overall the physicians in FHP were there because they were tired of the situation they were coming from. I know many physicians I would talk to said, "I got sick and tired of fighting the office hassles, the billings and collections. I felt I was spending more and more time in business and less and less time practicing medicine." I know my brother-in-law would love to work for an HMO and do nothing but surgery.

Hughes: I think a lot of physicians feel that way.

Johnson: Yes. You mentioned malpractice. That's becoming an even bigger and bigger piece of the problem.

Leaving FHP, 1990

Hughes: You left in June of 1990. Why?

Johnson: Actually, there were several reasons. I wanted to get out of southern California. I'd been there since '68, and I didn't like what was happening in the area.

Hughes: You mean growth?

Johnson: Growth, and too many people. I didn't like raising my kids there. I grew up in a little farm town in Illinois with corn fields in the backyard. I always swore I'd never live in a big city. I had an opportunity to move to this island and the kids can roam and we don't have to worry about them.

Hughes: What is the location?

Johnson: It's an area called Cape Hayes. It's south of Sarasota [Florida], near Boca Grand.

Hughes: Are you retired?

Johnson: Yes.

Hughes: At a very young age.

Johnson: Well, I'm forty-seven now.

Hughes: That's young. [laughter]

Johnson: I had an opportunity and I decided to take it. It was a tough decision. I don't miss working as such, but I certainly miss the camaraderie with the guys, with the management team, including Dr. Gumbiner. I miss the banter that we used to have. But I don't miss a lot of the other things.

Hughes: So it was a good decision overall.

Johnson: Oh, absolutely. I haven't had a second of doubt. My wife still has yet to be convinced. [laughter]

Hughes: Give her time.

Johnson: She's coming around. She occasionally goes on shopping trips to California. I think the time was right for me because it was no longer the FHP I knew.

Hughes: Did you know at that point that Dr. Gumbiner was close to retirement?

Johnson: Yes, I knew he was planning it. But I don't think that contributed to my decision. I had to make the decision; my daughter was getting ready to start high school. It was either make the move when I did, or wait four years, and I didn't want to wait four years.

Hughes: Is there anything more you want to say?

Johnson: I'm glad that somebody is going to chronicle what's gone on at FHP, not only for the people who were involved in it, but for the industry. Dr. Gumbiner has always been seen as the master in terms of being a teacher and a knowledgeable person in the industry. To get that chronicled I think is critical. His philosophies in dealing with and training and educating people are not necessarily unique, but the way he goes about it perhaps is. He's a fascinating guy.

Hughes: Do you have any thoughts on the future of the company without him?

Johnson: I think it will be strong. It will have its rough spots because it's been so long under the very steady and very strong hand of one person. Coming out from under that has got to be a bit traumatic at times. It won't stumble so much, but it will have its problems to be dealt with. They may have to change management staff for a while until they get the right mix. It was a lot easier when it was only a couple hundred people instead of 8,000 people, or whatever it is today. But there are some good people there. There are some good people in the ranks coming up that will make it a strong company. I still own a considerable amount of the company, so I've got faith in them.

Hughes: Well, I thank you, Mr. Johnson. This has been wonderful.

Johnson: I appreciate it.

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University of California
Berkeley, California

AN INTERVIEW WITH DAVID E. LESUEUR

Interviews Conducted by
Sally Smith Hughes
in 1992



David E. LeSueur, 1986

BIOGRAPHICAL INFORMATION

(Please write clearly. Use black ink.)

Your full name David Ellsworth LeSueur

Date of birth 11/21/49 Birthplace Mesa, Ariz

Father's full name Leo R. LeSueur

Occupation Accountant Birthplace Mesa, Ariz

Mother's full name Thelma Ellsworth Leslie

Occupation Secretary Birthplace Mesa Ariz.

Your spouse Nancy L. (Rigby) LeSueur

Your children James, Tyler, Nathan, Jill, Carrie,
Stacy, Kristen

Where did you grow up? Mesa Arizona

Present community Gilbert Arizona

Education B.S., M.B.A

Occupation(s) 1976-1987 Health care Mgmt

1987-Present Self employed

Areas of expertise Real estate development, Finance,
Farming

Other interests or activities Farming/Ranching

Hunting/Fishing Golf, Tennis, Basketball

Organizations in which you are active United Food bank, Boy Scouts
of America, L.D.S. Church, Community Politics

INTERVIEW HISTORY

David LeSueur joined FHP in 1976 after completing a master's degree in business administration at Brigham Young University and remained with the company for eleven years. As was the custom at FHP, he entered the company's management training program. A year into the program he was asked by Robert Gumbiner to serve as his assistant, following Hal Johnson and Jack Massimino as assistant to the president. The position provided an overview of the company and also, as he states in the oral history, "cemented a relationship with Bob that I enjoyed throughout the years."

In 1977 LeSueur became general manager of Health Maintenance Life Insurance Company, an FHP subsidiary which had been struggling through a succession of presidents. By the end of his two-year stint with the company, he not only had become president but also had solved the subsidiary's financial problems. In 1979 LeSueur became manager of the Utah region, replacing Jack Massimino and placing the region on sound financial footing. By 1984 he needed a new challenge and moved back to "corporate" in California as senior vice president of all regions and subsequently became executive vice president.

LeSueur was interviewed by telephone on February 18, 1992. Seeming to enjoy an almost filial relationship with Dr. Gumbiner, LeSueur is able to provide insight into the man and his work habits as well as on some of the turning points in FHP history. In 1987 he left FHP to test the entrepreneurial skills which he had learned at his mentor's knee. LeSueur now lives with his wife and seven children outside Gilbert, Arizona, where he is involved in real estate development, finance, and farming.

Sally Smith Hughes
Interviewer/Editor

October 1993
Regional Oral History Office
The Bancroft Library
University of California
Berkeley, California

VIII AN INTERVIEW WITH DAVID E. LESUEUR

Background

[Date of interview: February 18, 1992, by telephone to LeSueur's home in Gilbert, Arizona] ##

Hughes: Let's start with where you were born and educated.

LeSueur: I was born and raised in Mesa, Arizona, and educated at Brigham Young University, where I majored in agricultural economics with emphasis in business and economics. I then went through BYU's Master of Business Administration program, and completed my education in early 1976.

Joining FHP, 1976

Hughes: And from there, I understand, you went directly to FHP.

LeSueur: Yes, I joined FHP right out of school.

Hughes: How did you learn of FHP?

LeSueur: I have two brothers who are physicians, one older and one younger. The military had put the older one through school. He was paying back the army [in service] time, stationed in Tooele, Utah. FHP had opened a region in Salt Lake City in the mid-seventies. My brother was moonlighting with FHP and was very impressed with the organization and its philosophy. He introduced me to Hal Johnson who was then the regional manager of FHP Utah. Hal then in turn introduced me to Bob Gumbiner.

Hughes: Had you been interested in health maintenance organizations prior to that?

LeSueur: Not particularly health maintenance organizations, but I had targeted two or three industries that impressed me and health care was one.

Hughes: What was your position and what was the state of FHP when you arrived?

LeSueur: FHP at that time had a management development training program that Bob Gumbiner had pioneered. Because the industry was in its infancy, there wasn't any silver hair in the industry that he could pirate away from competitors or others in the industry. So he decided to roll his own, if you will, to start a management development program. His practice was to hire young MBAs right out of school into his management development program. Then he would have them serve for anywhere from a year and a half to two years, rotating through all of the functional management areas. Then based on corporate needs and the candidates' desires, he would try to find a good match and place them in an entry-level or a mid-level management position and give them their first line management responsibility.

Hughes: So he watched quite closely during this year and a half or two-year period.

LeSueur: Very closely.

Hughes: Was he trying to match you to the particular job he had in mind at the end?

LeSueur: That was the general goal. My experience was a little different than some. I spent about a year going through these functional areas of finance, marketing, medical affairs, and operations. At the end of a year, I got a phone call from Bob Gumbiner who asked if I would like to serve as his assistant, as the assistant to the president. A couple of others had also had that experience, Hal Johnson being one and Jack Massimino another. I was excited about that opportunity and served as his assistant for approximately six months, which was very, very helpful to me. It provided a broad overview of the corporate philosophy and problems facing the corporation at that time. I felt it cemented a relationship with Bob that I enjoyed throughout the years.

Relationship with Dr. Gumbiner

Hughes: What sort of a relationship did you have with him?

LeSueur: I ended up reporting to Bob for the entire ten or eleven years I was at FHP. From the time I became his assistant until I left, I reported directly to Bob Gumbiner.

Hughes: What sort of a man was he to work with?

LeSueur: He was the classical entrepreneur, in my eyes--a remarkable individual, a tremendous mentor. He was as well read in a wide variety of areas as any individual with whom I've been acquainted. He had a tremendous appetite for learning, an insatiable appetite.

Hughes: Are you thinking mainly in terms of business?

LeSueur: Not just business, but from the arts to music to architecture. I often felt he was a frustrated architect. He had many, many talents and many interests. He was a health nut and enjoyed sports a great deal, as I and many others in the organization did. We played racquetball or tennis or jogged from time to time.

Hughes: Was it typical of him to have a relationship outside of work with his key people?

LeSueur: I wouldn't say real typical, but he had some associates in the organization that I think he felt he shared some common interests with that spawned that kind of relationship.

Hughes: What did he see in you, do you suppose, to make you his special assistant?

LeSueur: I don't know. As I mentioned, I wasn't the only one who served as the assistant to the president. Maybe he saw some initiative, some get-up-and-go and a real interest in the organization. I was very interested in what we were doing and why we were doing it and had a real desire for the organization to be successful.

Hughes: Was he trying to bring the best out of you? Or was it more, "What's good for FHP?"

LeSueur: I felt that he had a genuine interest in me personally and individually. He was a man who counseled, when he saw a mistake being made. He was not just quick to point out the mistake but to point out alternative solutions or other approaches that might

have been taken. I felt he had a great deal of interest in trying to help me personally. I wouldn't say that was true of all the employees at FHP. He seemed to take a significant interest in some who perhaps he thought were going to be successful or had perhaps the latent skills necessary to help the organization along. Those he took great interest in and worked quite a bit with personally.

He seemed to recognize that I hadn't had the opportunity to do nearly the kind of traveling that he had throughout his life. I was frequently very appreciative. Whenever we would visit Washington, D.C. or some other place, he would always find time to show me some of the sights, maybe a couple of the museums that I had never frequented before. I felt he took a real personal interest.

Hughes: Was he a tough person to work for?

LeSueur: Yes, he was, in many ways--very demanding and exacting but, I felt, very honest and straightforward. I could live with that. I seem to thrive in that kind of environment. He demanded a great deal from himself and was a hard worker, very industrious, very shrewd. I enjoyed working with him a great deal. I still consider him not just a friend but have a great deal of respect and admiration for him.

Hughes: You were his assistant for six months. Was there a reason for only six months?

Running Health Maintenance Life Insurance Company

LeSueur: At the end of the six months, we had a little subsidiary, a little life insurance company, that had been struggling. He had had four or five presidents of this company in a matter of about five years, each of whom he felt had failed in some way or another. He approached me one evening late, as it was our habit to work late into the evenings (he is kind of a nocturnal creature), and said, "We have this little subsidiary. It's got one foot in the grave and one on a banana peel." [laughter] "I don't know whether to try to resurrect this thing or shoot it and put it out of its misery. I have concluded that all of these former presidents we've had in this company have been handicapped by one common malady. That is that they have come out of the insurance industry and are steeped in the tradition of the industry, and I'm trying to do something new, different and innovative."

Hughes: This is Health Maintenance Life?

LeSueur: Yes. It was known in those days as HML, Health Maintenance Life Insurance Company. He said, "I would like to do something innovative and different and I can't do it with the fetters of tradition that we seem to keep having in these past presidents. I would like to get somebody in there who knows absolutely nothing about insurance, but who has some business sense and would like to try to make this thing work."

Hughes: Did he tell you what his ideas were?

LeSueur: In broad philosophical terms he did. I told him that evening that I really hadn't joined FHP to run an insurance company, and that it seemed quite foreign to me, and I wasn't sure how excited I could get about it. I told him I would like a little time to think about it. He said, "Great. Think about it, meet me for breakfast and give me an answer." [laughter]

So that's what I did. I went home that evening, visited with my wife, lay down on my bed and thought about it for a while. I thought it was really every MBA's dream. It's a sick dog. If you turn it around, you're going to be a hero. If you don't, five or six other good people haven't been able to either. It won't be the end of the world. So I decided to take him up on the offer.

Hughes: What happened?

LeSueur: We had a great experience. It was very difficult. The company was already in trouble with the Department of Insurance. The commissioner had us on his early warning reporting list.

Hughes: Why was that?

LeSueur: Because of its struggles financially. The commissioner was convinced that unless it were recapitalized, it didn't have the funds necessary to back the policies it was writing. Because of that, the commissioner then had us reporting monthly instead of quarterly. Any time the commissioner would see any kind of losses at all, or capital and surplus that he felt were in danger, then we would get a call and he would threaten to take the company over unless we put some more money in, recapitalized.

So probably the first six months to twelve months were a real struggle, but we made some very rapid gains. Marketing took off very well. That helped fund some of the growth that was necessary to get the company out of trouble. It hovered near break-even. We would make a little money and then lose a little

money, but grew very rapidly and became more stable each reporting period. I started as general manager and then I think served as executive vice president and then president. I don't remember the dates of those moves but I think I was there basically from about the last half of 1977 until the end of 1979. So a little more than two years.

Manager, Utah Region, 1980-1984

Hughes: Why did you leave?

LeSueur: We had a good manager in our Utah region who left us kind of precipitously just before Christmas, 1979. He's probably another individual you've talked to or will talk to, and that's Jack Massimino.

Hughes: Yes.

LeSueur: I don't know whether Jack fell out of bed one morning and decided he wanted to get into politics or what happened, but he left us on pretty short notice. Or at least Bob felt he left us on kind of short notice. I remember sitting around the table and Bob asked all of the FHP corporate VPs at that time--even though I had the title of president of HML, I wasn't considered a corporate VP because I was running a subsidiary and was quite a bit younger than most of the others. But we sat around the table one day and Bob said, "Who's going to Utah?" He offered it to several of them. They all had good reasons why they couldn't or shouldn't go. It probably sounded like outer darkness to them. So I raised my hand and said, "I'll be happy to go."

Hughes: What did you see in Utah?

LeSueur: By then, we were enjoying some pretty good success at HML. I was feeling good about the experience there but really had, I felt, done what was asked of me and I was looking for a new challenge. Utah, which we had opened in 1976, had struggled, had never really made money. It was about a break-even proposition at best. It would lose a little and then make a little. It wasn't enjoying great success in marketing. I think Jack had made some progress but they were very poorly diversified at that time. They had a CHC [community health center] contract, which was a near-poor contract, to provide health care to the nearly indigent. Then they had a Title XIX [Medicaid] contract to provide health care to the poor. They had a couple of other key

contracts but basically they were very poorly diversified. It sounded like a great challenge to me.

So I volunteered to go. To my utter amazement, Bob thought that was a good idea, probably by default since his other corporate VPs had not shown much interest. So I went. We arrived, I think, in December of 1979, my wife and I. We were there until about the middle of 1984, a little more than four years.

Hughes: Were some of these problems inherited from the group [Utah Group Health Plan] that FHP bought out?

LeSueur: Yes.

Hughes: Had the organization changed much since then?

LeSueur: I think some good progress had been made. Hal Johnson and Jack Massimino both had made some progress. But it still financially was kind of teetering on profitability.

Hughes: What did you set about to do?

LeSueur: I didn't do much for the first four or five months. I just looked carefully at the organization and the management team and decided basically that a number of changes needed to be made, both in the management team and in the strategy of the region. I decided that we needed to get very, very aggressive from a marketing perspective. So immediately then, we did our homework, our research, through Dunn and Bradstreet, chamber of commerce, telephone books, everything else we could do. We listed every employer in the entire Wasatch front and prioritized them by size. Then we assigned every employer to a sales rep.

We basically doubled or tripled the size of the sales department. We brought in a good sales manager who had worked for us in California, and really got aggressive. It paid handsome dividends for us. I think that within about a two-year period we were growing more rapidly and were more profitable on a percentage basis and, in some months, even in gross dollars, than any other region.

I wasn't sure that Utah was going to be that strong a market. I had first thought that they might be such a conservative population that this radical form of health care delivery might not meet their tastes. But I was very pleased to find that they had a tremendous appetite for affordable health care and that our "bolshevik" approach to delivering health care wasn't unpalatable to them at all.

Hughes: Does FHP have a standard training program for sales people?

LeSueur: I don't know what they have now, Sally. In those days, we had an orientation program and we had sales managers who would then, after the orientation program, work with the sales rep. But I wouldn't call it a sophisticated, formalized program. We tried to find people who already had some sales experience and who had proven themselves successful.

Hughes: And they went out to the corporations and made presentations.

LeSueur: Right.

Hughes: How did you come to pull up stakes in Utah?

Senior Vice President, 1984-1986

LeSueur: Well, I had been there a little over four years and Bob Gumbiner seemed again to sense that--I wouldn't say "mission accomplished"--but the major objectives for which I went to Utah were well on track. I was getting bored and needed a new challenge, and he began to talk to me about some new challenges back at corporate. I decided that that would be a good experience and moved back to corporate initially as a senior vice president over all of the regions, and then later as an executive vice president.

Matrix Management System

Hughes: Had the matrix system been installed at that point?

LeSueur: Yes, it had.

Hughes: Could you talk a little about the matrix system?

LeSueur: The matrix system initially wasn't real attractive to most of management in place. I would count myself among those who may have been a little skeptical and dubious.

Hughes: Why were you skeptical?

LeSueur: We felt, as a management team, that we were not a "destroyer" as an organization; we were a "PT boat". Our ability to maneuver

very rapidly and make decisions very quickly and marshal resources very quickly was imperative to our continued viability. We felt that was what had brought us success historically. While the rest of the industry was trying to turn around, we could circle them ten times in every strategic area.

Hughes: Why was that?

LeSueur: Because we were very small. Our roots had been in entrepreneurial management. Bob Gumbiner epitomized entrepreneurial management. He could walk into a room and assess a situation and make a decision, and that afternoon we were implementing it. We could present to Bob a problem with a recommended solution. He would say, "I think that makes sense to me," and we were off and running. I could make a phone call from Utah and say, "Here's what I want to do; this is why." He would say, "That makes sense." Of course if it were imperative, I just made the decision and implemented it and told them about it afterwards. If I were wrong, I felt Bob Gumbiner's wrath, and if I was right, it showed up on a performance evaluation.

When we implemented the matrix, decisions slowed significantly. Now you had twice the number of people involved, the lines of authority were not clear at first, and people weren't used to it. It represented change. There were some really strong territorial feelings: "This is my region. This is my functional area. Who could be better qualified than I? I have been here x number of years." Or whatever the feelings were. So there was some real concern.

Hughes: Why did Dr. Gumbiner think the matrix system was a good idea?

LeSueur: I think at the rate we were growing and given our background, we didn't have a tremendous amount of maturity in a lot of our management positions. We were still bringing up young people, like myself, and probably giving them responsibility before they were ready, but by necessity we had to. The cream would rise to the top. We had a significant mortality rate; we lost a lot of people. A lot of people couldn't make the grade. Even in the management development program, there was almost a 50 percent death rate. People just washed out.

I think Bob felt we were beginning to become a significant size and organization. Now we had three regions acting quite autonomously, depending on the management team in place. If you had a really aggressive manager in one region, he or she might do three or four things the other regions had never thought of or heard of. We probably weren't sharing as much information as we could have. Bob probably felt that we could improve the quality

of the decisions if we had more good minds working on the problems.

Hughes: Was this system in place in many organizations?

LeSueur: No. It was almost ethereal and academic in nature. We had read about it in a couple of books. We knew that there were a few organizations that had been experimenting with it. Some had had it in place. But Bob felt strongly about it and implemented it and we struggled with it.

Hughes: Had he simply encountered the description of the system in one of his management courses?

LeSueur: Yes, and in a book. We had a couple of books that he later made available to us that we could read. But I think he initially became aware of it in the literature and then did some reading and some thinking and thought it was a good idea.

Hughes: Is the matrix system still being used at FHP?

LeSueur: Sally, I left FHP a number of years ago, so I couldn't tell you that.

Hughes: When did you leave?

LeSueur: June of 1987. I later became one of its disciples and thought the matrix had a lot of benefits. I didn't get there immediately but after working with it for probably a year and a half, maybe two years, I could see a great deal of positives and a great deal of benefits.

Hughes: That outweighed the negatives.

LeSueur: Yes, I would say so. In fact, I had heard a year or so ago that FHP had discontinued the matrix and that troubled me a great deal.

Hughes: You were then a senior VP.

LeSueur: Yes, and then an executive VP.

Hughes: What is an executive VP?

LeSueur: It's in between the president and the senior VPs.

Hughes: Is there one?

LeSueur: There were two of us, typically only one or two. There are usually not many executive vice presidents in an organization.

Hughes: Is this a regional/functional dichotomy again?

LeSueur: Yes, although by then we had started experimenting, Bill Price and I and Bob Gumbiner, with breaking up the functions and the regions differently. So it seems to me that Bill and I might each have had a region or two and a couple of the functional areas. We didn't feel the need to keep it totally regional versus totally functional. There were some areas where we might both have some expertise or one might be stronger than the other. In some instances we just tried to balance the load.

Hughes: If I am understanding the matrix system correctly, one of its attributes is that the decisions are made largely by the people below the CEO [chief executive officer], leaving him free to make more sweeping decisions. Is that indeed the case?

LeSueur: I would say that is one of the benefits. I wouldn't consider that the most significant by any means, because even in a vertical hierarchy, if a CEO wants to be involved with lower-level decisions, he gets involved. And if he doesn't want to be involved, he doesn't need to be involved. It's almost a matter of personal taste. The same can happen with a matrix. Even when you have a matrix in place, if the CEO wants to get involved with how the artwork is hung, he'll get involved.

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Hughes: When the matrix system really got off the ground, Dr. Gumbiner was as active as he had ever been in all the levels of organization?

LeSueur: Yes, I would say so. I don't think it changed his personality much, but I think that when solutions to problems were presented to him, he probably enjoyed knowing that more than one mind had thought about them and maybe a couple of layers of management had considered the problem. That may have left him feeling freer to not spend so much time on what he might consider mundane matters. He may have just felt the quality of the decision-making had improved.

Expansion and the IPA

Hughes: Do you have anything to say about the expansion into New Mexico and Arizona?

LeSueur: I was part of both of those expansions and supported both wholeheartedly. I felt that Albuquerque was a little small. I wasn't as excited about the New Mexico market as I was the Arizona market. But I felt that expansion was wise and felt that Arizona in particular had a great deal to offer.

Hughes: Why was the IPA used so heavily in those two areas?

LeSueur: The IPA is a faster method of growth. You can use facilities that are in place, physicians that are in place, a health care delivery system that is in place. Its success depends on the quality of the contracts that are negotiated. The follow-up in terms of management that must take place is to see that the delivery system is not just adhering to the quality of care we required but the quantity as well, that is, that they are not over-utilizing.

Hughes: It's a large leap from a staff model to an IPA.

LeSueur: It is. But most people forget that an IPA concept was not a stranger to Bob Gumbiner. We had experimented with an IPA in Guam in the early seventies. Before the mainland had even dreamed of IPAs, we had one in Guam that was successful. Again, it was successful because of some very innovative contracting methods that we had made use of, most of which Bob had pioneered.

Hughes: Why did the IPA seem appropriate for Guam?

LeSueur: A couple of reasons. When we went to Guam, the competing carrier on the island, AFIA, was the only other carrier I think that had a GovGuam (government of Guam) contract, or a federal contract, on the island. I can't remember which. When we came to the island, they immediately for the first year tried to do, in our opinion, some significant predatory pricing. They ended up losing a significant amount of money that year and we were profitable. In the aftermath, they decided to pull out and they left the island. We were the only contractor then to provide health care to these people.

Bob Gumbiner didn't feel it was right to force them all into a staff model. He wanted the people to have a choice. He knew that if they were forced into one model, they wouldn't be happy

and we would have all kinds of problems. So he invited some other insurance carriers to come to the island and either serve as indemnity carriers or IPAs or some other form of health care so that the people would have a choice. He had no takers. Nobody would go. So he thought, "I'll form an alternative delivery system so that people will at least have a choice between indemnity care and FHP," a staff model HMO. That's when he founded Health Maintenance Life Insurance Company. He went over and had HML contract with the island's physicians in an IPA format so that people would have a choice.

So when we expanded in southern California, Arizona, and New Mexico, we had already had a fair amount of experience in an IPA format. We just hadn't used it in southern California where we were almost exclusively staff model. So we made use of it.

Hughes: In general, it worked?

LeSueur: You never have the same control in an IPA that you do with a staff model, but it's a much more rapid way of growing. It can work, especially when it is backed up with a staff model, when the physicians can see that if they don't play ball and don't behave themselves, they can literally lose the market to the staff model.

Hughes: Do you have staff models in place in Arizona and New Mexico?

LeSueur: You would have to ask current management at FHP, but I believe that is the case, Sally.

Hughes: You didn't at the time you were there?

LeSueur: We actually did. They were very small. We had a very small medical center in Arizona and they were working on one in New Mexico. It was primarily IPA, but we were beginning to implement our strategy of backing them up with a staff model.

Federal Charges of Diversion of Funds, 1976

Hughes: I want to hear a little about the troubles of the 1970s. I'm thinking specifically of the charge which was leveled in 1976, not just at FHP but also at four other HMOs, that federal and state money for Medi-Cal had been diverted to profit-making affiliates. Do you remember the situation?

LeSueur: Yes. I had just joined the company. Jack Massimino was the assistant to the president at that time. In fact, I do remember that when the story broke and RG [Robert Gumbiner] ended up testifying in Washington, we then began getting requests from the state and others to audit us and that compounded our problems. We lost our Title XIX contract, as no doubt you know.

I was convinced that that was going to be such a significant financial detriment to the organization that the first thing Bob Gumbiner would do would be to let all of these management development candidates go. It seemed almost a luxury at the time to have on the payroll all these young MBAs he was grooming for a position. So I called a number of management development candidates and we had lunch at my home on a Sunday afternoon, I think it was, and I remember asking these guys what they were going to do after life at FHP. Bob Gumbiner called a meeting a few days after that and said, "The last thing we are going to do is let good management people go. We are going to cut out all the deadwood. We are going to market our way out of this problem. But we are not going to lose our good people. Don't panic." And he was very wise in doing so. I was impressed. At an early age, he had enough vision and wisdom to know that once he started letting management people go, it wouldn't be long before the company would be in its coffin.

Hughes: There was its future down the drain.

LeSueur: But as to the allegations, I read about them, I was aware of them, but only from the periphery. I was just too new to know a great deal. I was in the functional area of facilities and had done a study for Bill Rosecrans who was the manager of that area. I had done the study on my own time that showed what would happen if we ever lost our Title XIX contract. Our Title XIX patients represented about a third of our patient population but almost 40 percent of our income. But the thing that concerned me most was that they were largely taken care of in three of our six or seven medical centers and that if we ever lost that Title XIX contract, those centers would be empty.

I finished the report, gave it to Bill Rosecrans, and told him that I thought we were poorly diversified. He said, "This is a great report. This is something we haven't thought about. I'll send this to the vice president of FHP," who at that time was Carmen Ness.

He read it and I think round-filed it, threw it away. I remember him saying, "Why on earth would you think we would ever lose our Title XIX contract? We have had this thing for years; the government loves us; we are doing a great job. What you had

to say is of academic interest but that's all. It's just not going to happen." About four months later, we lost our contract. Then Carmen Ness wanted to know if I had a copy of the study I had done which suggested some possible solutions to empty health care centers.

I don't know how useful it became, but in any event it was ironic. They were troubled times and Bob Gumbiner, true to form, instead of getting weak-kneed and backing up, gripped the steering wheel and put the accelerator to the floor and we marketed our way out of that mess and stayed alive.

Hughes: Very quickly as I understand.

LeSueur: Yes.

FHP's Transition to For-Profit Status, 1986

Hughes: Another area I wanted to hear from you about is the transition from nonprofit to for-profit in 1986.

LeSueur: We started working on that about the end of 1984 and into 1985. A great deal of work went into that. We converted long before I left.

Hughes: Why was it thought a good idea to convert?

LeSueur: There were a couple of reasons. We were generally a staff model. As a staff model, it took tremendous capital to grow. It was difficult to borrow. We didn't like the idea of being highly leveraged. We weren't on the bankers' list of preferred customers. When I say, "We," I mean the entire [HMO] industry. We needed to raise capital. That was one primary objective. We needed to raise capital and the traditional forms of debt really weren't available to us in significant size.

Secondly, we felt we needed to attract good quality management people. A number of our competitors had already converted and were able to offer management individuals equity opportunities, stock options, and other alternatives that were very attractive. We were without that opportunity. We felt that converting to for-profit would be most helpful in that area. Those were the primary motives, I would say.

Hughes: Was there any opposition within FHP?

LeSueur: There was a great deal of debate. Philosophically, it was so foreign to what we had done in the past. I wouldn't say that there was tremendous opposition but there was a lot of questioning. Would this be the best thing to do? What would it cost the organization? Would we lose control? Would we become so profit-oriented that we might compromise quality of care? A lot of people asked a lot of questions.

Dr. Gumbiner, Bill Price, and I were initially the three who spent a great deal of time working on the project, and later Burke Gumbiner helped us. Then we chewed and chewed and chewed on that issue and became convinced that it was the smart thing to do and the right thing to do, and the board--most of us were serving on the board at that time--also felt it was the wise thing to do. So we pursued it.

Hughes: As I understand it, one of the things that California law requires you to do under those circumstances is to make a charitable donation. How was the amount determined?

LeSueur: We immediately hired an outside accounting firm, Ernst & Whinney. They sent a couple of representatives to do what we felt was an exhaustive study of all assets and liabilities to try to find the net worth of the organization, which then needed to be donated or gifted to other like-kind charitable organizations under the state's purview.

Hughes: FHP made the decision as to where it was to be gifted?

LeSueur: Not without the state's blessing. The entire plan had to have the state's blessing.

Hughes: Where did it go?

LeSueur: That's a good question. I'm trying to remember now. I think the bulk of it went to the FHP Foundation, which was a nonprofit organization, which then funded a number of community health projects and other projects. But it was the vehicle for contributing to the community those proceeds.

Hughes: When had the foundation been set up?

LeSueur: About the same time. It was to be the entity that would discharge these responsibilities, with the state's blessings.

Hughes: But that wasn't its sole function. It had a life after the distribution, did it not?

LeSueur: Yes.

Hughes: What did it do?

LeSueur: I had very little contact with the foundation and really couldn't tell you. I didn't serve on its board.

Hughes: Maxicare enters the picture during the conversion process. What happened there?

LeSueur: Maxicare, I believe, was the first to convert from nonprofit to for-profit status at an incredibly low valuation, we felt. Then, right in the middle of our conversion process, at the last moment, Maxicare felt that the conversion could be construed as a public auction, and they wanted to purchase FHP, so they made a bid. The Department of Corporations communicated to them that it wasn't an auction; it was a valuation. Maxicare decided, I think, that they could significantly muddy the waters by suing the attorney general and FHP to preclude the conversion and force them to entertain their offer. They didn't realize that the valuation was higher than their offer.

They filed suit. The attorney general, I think, decided that he could step forward as the rescuer of something that he could consider to be inappropriate. He stepped forward and asked the Department of Corporations to cease the conversion, communicated that he wanted to be involved, that he wanted the right to review the valuation, that it shouldn't be left to the Department of Corporations. And then the suits and countersuits began.

Hughes: Including one which wasn't directly related to the Maxicare business from the California attorney general, claiming the inadequacy of the charitable settlement.

LeSueur: It was directly related to Maxicare's charge. Maxicare sued the attorney general and FHP and said, "Mr. Attorney General, you're not doing your job. You need to get over there and police this conversion under common law." The only reason the attorney general got involved was because Maxicare fired a shot at them. That's when the attorney general inserted himself and said, "Yes, gosh. Maybe we ought to take over this conversion and maybe the law didn't really give this to the Department of Corporations to officiate."

Hughes: Was that more or less the end of that?

LeSueur: No, we then had to fight it out in court to show that the Department of Corporations was indeed the entity responsible by statute to conduct the conversions. That's what we did. We felt that as much as anything, the whole dispute was a territorial

dispute between the attorney general and the Department of Corporations. They could have used any HMO they wanted to. We just happened to be the one who was converting at the time. But the AG wanted to expand his territorial role and get back into the conversion business.

Hughes: That set a precedent.

LeSueur: Yes, the courts then found that indeed the Knox-Keene legislation and other legislation had intended that the Department of Corporations be the entity responsible for conversions.

Dr. Gumbiner's Retirement, November, 1990

Hughes: Tell me about "staged development" in the office of the president. Is that the right term?

LeSueur: I don't remember that term.

Hughes: Well, maybe it was used after you had left.

LeSueur: It took place after I left. Manpower planning and transitional planning we had given some thought to and contemplated for some time. But a firm date for Bob Gumbiner's retirement had not been planned when I left.

Hughes: So you don't know why he decided to retire when he did.

LeSueur: Well, we all thought that it wouldn't be long. We knew that even though he was in great health, he was at an age where he had lots of other interests and lots of other opportunities. His retirement wasn't a significant surprise.

Hughes: What is the company like without such a potent figure as Dr. Gumbiner? I realize he is still chairman of the board so he is hardly out of the picture completely.

LeSueur: It's hard to assess that. There is no question about the fact that Bob Gumbiner has been a tremendous asset to the organization. He was the organization initially and continues to be a significant asset. But as any corporation grows and matures, it requires a different kind of thinking and a different approach. I personally felt that Bob was one of the few entrepreneurs who could continue to grow and mature with the corporation he had founded. Many can't make that transition. He did a great job of doing that and seemed to anticipate when

change was needed. He'll be a loss; there is no question about it.

On the other hand, I'm convinced that a good management team can keep the company viable, growing, profitable, and successful for decades to come. The industry still is ripe for the kind of solution FHP is offering. In fact, problems in health care in this country may mean that FHP becomes more successful over time, not just FHP but alternative forms of health care. I think the country is tiring of the traditional method of delivering health care.

Leaving FHP, 1987

Hughes: Why did you decide to leave in 1987?

LeSueur: I had had a great career and super opportunity with FHP. I left with the best feelings and had a nice visit with Bob Gumbiner. In fact, he asked me at the time if I would like to consider staying on the board as a director.

But I had communicated to Bob many years prior that if I ever left FHP, it wouldn't be to join a competitor, but it would be to be an entrepreneur myself and pursue some of my own dreams and aspirations on a personal basis. I think he understood that. He was disappointed, and I had had a great experience at FHP. But that was in fact what I wanted to do. I felt ten or eleven years was a significant period of time and was really anxious to try some other things. Our oldest child was just approaching junior high and high school and I thought that if we were ever going to make a move, that was the time to do it. It would be less traumatic for the family if we did it then. So we did. But I have nothing but good feelings and admiration for Bob Gumbiner and FHP.

Hughes: Is there anything you want to add before we stop?

LeSueur: No, nothing, except that if what is recorded ends up being a tribute to Bob Gumbiner, I can't think of a business leader more appropriate to receive it. He's an outstanding individual in his field and a good person.

Hughes: I'm sure he'll be pleased to read this eventually. I thank you very much.

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AN INTERVIEW WITH CHARLES A. LIFSHULTZ, M.D.

Interviews Conducted by
Sally Smith Hughes
in 1992



Charles A. Lifschultz, M.D., 1983

BIOGRAPHICAL INFORMATION

(Please write clearly. Use black ink.)

Your full name CHARLES ALAN LIFSCHULTZ M.D.

Date of birth 11/22/22. Birthplace CHICAGO, ILL.

Father's full name ISADORE LIFSCHULTZ

Occupation SALESMAN Birthplace RUSSIA

Mother's full name PAULA DAVIDSON LIFSCHULTZ

Occupation HOUSEWIFE Birthplace GERMANY

Your spouse MARGORY VOSTERMARK LIFSCHULTZ

Occupation RN / HOUSEWIFE Birthplace IOWA

Your children ILONA LIFSCHULTZ DADINIS ; PAULA A. LIFSCHULTZ ;

JACKIE LIFSCHULTZ COYNE ; SHAWN A STEFFAN ; SANDRA I. STEFFAN

Where did you grow up? CHICAGO

Present community FOUNTAIN VALLEY, CA.

Education BS, ROOSEVELT UNIVERSITY, 1949 ; GRADUATE WORK ANTHROPOLOGY,

U OF CHICAGO, 1949-50 ; BSM - MD, U OF ILLINOIS COLLEGE OF

Occupation(s) PHYSICIAN MEDICINE, 1954

EX-MUSICIAN ; CAPTAIN MILITARY INTELLIGENCE / OSS IN WWII

Areas of expertise MEDICINE / F.P. ; CULTURAL ANTHROPOLOGY -

LANGUAGES

Other interests or activities MUSIC ; FOOD & WINE ; LITERATURE

Organizations in which you are active AAFP

INTERVIEW HISTORY

Charles Lifschultz's association with what was to become FHP began in 1959 when he answered Dr. Gumbiner's advertisement for an associate to join him and his partner Charles Eubanks in the Plaza Medical Group located in Long Beach, California. Of those interviewed for this project, he easily has the longest association with FHP aside from Dr. Gumbiner himself. He is also, remarkably, the only physician to be chosen for an interview.

In the oral history, Dr. Lifschultz tells of the evolution of the Plaza Medical Group from fee-for-service, to a combination of fee-for-service and prepaid group practice, to an exclusively prepaid form of medicine. In 1966 the medical group split up, divided largely over the disparity in income between the fee-for-service and prepaid practices. Only Drs. Gumbiner and Eubanks remained in the Plaza Medical Group, and Dr. Lifschultz and four of the other "dissidents" set up a private medical partnership.

In 1976 Lifschultz suffered a myocardial infarction which caused him to give up his large and busy private family practice. He did a variety of things, all nonmedical, in the next few years, and in 1983 decided to return to the organization which was now FHP, lured by the patient contact he had missed and by the absence of night and weekend duty.

As the only physician, aside from Dr. Gumbiner, given voice in this project, Dr. Lifschultz's account of medical practice at FHP takes on added significance. Its significance increases further with the realization that Dr. Gumbiner speaks through his oral history more as a businessman than a practicing physician, which indeed he was not for most of FHP's history. The reader may be interested to compare the two accounts.

Dr. Lifschultz was interviewed on February 19, 1992, kindly agreeing to come to the corporate offices in Fountain Valley. As the oral history manifests, he is articulate, insightful, and frank. He is the only one in the oral history series to speak of the supportive role of Dodie Gumbiner, Dr. Gumbiner's ex-wife. Dr. Lifschultz is currently a family practitioner with FHP.

Sally Smith Hughes
Interviewer/Editor

October 1993
Regional Oral History Office
The Bancroft Library
University of California
Berkeley, California

IX AN INTERVIEW WITH CHARLES A. LIFSCHULTZ, M.D.**Background**

[Date of interview: February 19, 1992] ##

Hughes: Where were you born and educated?

Lifschultz: I was born in Chicago, Illinois, November 22, 1922. I did my undergrad work at Roosevelt University in Chicago, and attended medical school at the University of Illinois College of Medicine [1950-1954]. Prior to that I did graduate work in anthropology at the University of Chicago.

Hughes: With the thought of becoming an anthropologist?

Lifschultz: Yes, initially. My brother had gotten his Ph.D. there and there were some giants in anthropology there at the time, Robert Redfield and Sol Tax and some other very fine people. However, I discovered that it would cost as much for me to get my Ph.D. in anthropology as it would to get an M.D., and I already had a family in process. People in anthropology in those days were not getting much money.

Hughes: Any regrets about that choice?

Lifschultz: No. I did some field work and I enjoyed it immensely. But I had to decide between a Ford Foundation grant and entering medical school, and I opted for medical school. I don't regret it. I especially love family practice, always have.

Hughes: What happened after medical school?

Lifschultz: I trained at the L.A. County Hospital.

Hughes: What year would that have been?

Lifschultz: That was 1954. In those days, residency for family practice was not something that a lot of people were doing. If one chose to go into family practice, they often went directly [from the internship]. I toyed with thoughts of a residency, but nothing really seemed to be as appealing as family practice. Once again, something that I have not lived to regret.

Hughes: Was family practice a relatively new specialty at that point?

Lifschultz: Yes. Actually, it was a general practice residency at the time. Family practice per se didn't really come into existence as a formal entity until some time later, when it became one of the specialties and people took the exam and became accredited in it, which I did. I'm certified and recertified in family practice.

Following L.A. County I went into practice in Reseda in the San Fernando Valley for about four years [1955-1959], and because of burgeoning smog opted to come down to the beach areas. Dr. Gumbiner was advertising at that time for an associate.

Group Practice with Dr. Gumbiner, 1959-1966

Hughes: Was this the Plaza Medical Group?

Lifschultz: Well, it was Dr. Gumbiner, period, at that time. He had lost two associates, Dr. Knox and one other surgeon. He and Charlie Eubanks, who was a pediatrician, were the only two there at the time that I joined him.

Hughes: Now was this strictly fee-for-service medicine?

Lifschultz: This was strictly fee-for-service, and remained so for several years. Our group grew as a multispecialty group, to the point where, as I recall, we were thirteen at about the time that Dr. Gumbiner initially posed the question as to whether we should, as a noble experiment, go into a prepaid form of medicine in tandem. And this is what we did.

For about five to six years, we did fee-for-service alongside of the prepaid. We handled them both. That was the sticking point, that we discovered in the two years before we split that we were using substantial sums from our fee-for-service income to guarantee that the prepaids obtained the

same level of care. That somehow didn't seem to make sense to us.

I don't think that any of us really had the dedication to the principle of prepaid medicine that Dr. Gumbiner did. He and I went to a number of areas, together with Dolores Kellett, whose name I'm sure has come up. Dolores was initially Dr. Gumbiner's office nurse, and then as our group grew, she became the office manager. After the split she became a corporate executive with FHP as it grew.

Hughes: Had you heard of the concept of prepaid practice before?

Lifschultz: Yes, we were aware of it, and indeed, some of the travels that Dolores and Bob and I went on were to view it in action. At that time HIP [Health Insurance Plan] was in existence in New York, as well as Group Health of Washington, D.C., Group Health of Puget Sound, and the Stanford group.

Hughes: Russel Lee's organization?

Lifschultz: Yes. But none of them had arisen in the way that we envisioned ours arising, that is, as a free option of physicians nonaligned with either a university or any commercial or industrial organization such as Kaiser. The way most of the others arose was either through university affiliation or through business affiliation. So we considered it a noble experiment. [laughter]

Hughes: But you were a little skeptical?

Lifschultz: Not at the time. As I say, I don't think I was as ready to make a total commitment to it as Bob was, but I certainly was happy to give it every chance to succeed. Indeed, I felt that we did, in the format in which we were doing it. But none of the other physicians, other than Dr. Gumbiner and Dr. Eubanks, opted to continue with FHP, and so we split in 1966.

Hughes: Do you want to describe how that occurred?

Lifschultz: We had a number of discussions. Dr. Gumbiner was then, as he is now, an extremely complex individual, enormously skilled in the area of business and business affairs, I think much more so than his medical expertise. He was intensely committed to ideas when he had decided that this was the course he was going to take, and indeed, I think that's probably why FHP was able to survive and thrive thereafter.

Hughes: Do you have any insight into why he was so committed to the idea of prepaid medicine?

Lifschultz: I don't, and if I may be frank, it was somewhat surprising to me. But again, Bob is a very complex guy. With the attachment that he had to funds, he had done some things which I found amazing. As you may know, he was in freedom marches in Mississippi and Alabama of his own volition, something with which I had great sympathy, but I didn't have the guts to go down there. He did, and I much admire him for having done so.

In the course of our practice, as the group grew I became the chief of staff of the group for things medical and he was the chief without question as far as things financial and economic were concerned. But we had to admonish him on occasion. Someone would come in with an upper respiratory infection. Before he would leave he would have had a chest film and diathermy to the sinuses and a number of things which we felt were a bit much. That didn't happen all the time, but it did happen.

Hughes: You mean overtreatment.

Lifschultz: Overtreatment. So his commitment to the idea of prepaid medicine and cost-cutting in a sense, which equates to cost control, was surprising to me, and his rather marked attachment to it was even more surprising. We looked into a number of things at the same time that we were considering FHP, and among them were taking on the Retail Clerks [Union] and the Long Beach School System and that sort of thing. As it turned out, these organizations were the initial members of FHP on a commercial basis.

Hughes: Do you remember anything about the recruitment of both those groups?

Lifschultz: I remember hammering out rather long-winded negotiations with the Retail Clerks' representatives. Bob and I and Dr. Milliken from the Milliken Medical Group and several other physicians who had large groups were interested in the Retail Clerks particularly. I was not involved at all in the Long Beach School District situation. That was purely something that was in Dr. Gumbiner's bailiwick. FHP, despite my marginal involvement, was really his baby, the concept and the development. I was happy to go along with it and contribute what I could and work within the system that we had set up, but he was the prime mover without question.

Hughes: One of the bones of contention, I understand, before the formation of the prepaid group practice, was that the partners apparently expected him to not only deliver medicine as every partner was, but also to administer and run the group for the same salary. Do you remember that being the case?

Lifschultz: I don't remember it being the case to any significant degree, because he really didn't practice much medicine at all in the years that I was with him. We didn't dislike that at all. Plus the fact that the land that we were on and the building that we were in were owned by him, not by us, and he derived significant income therefrom. Of course the situation still obtains with FHP. This land and these buildings at the Fountain Valley office of FHP are owned by an entity of which he is far and away the majority stockholder. That's true of this area, that's true of Plaza, and it's true of the downtown Long Beach operation.

Hughes: So Plaza still exists?

Lifschultz: Oh, yes. Plaza exists and has been significantly enlarged. It was a single story building and it is now multi-story. There is an administrative section to it, which was where a lot of the corporate staff was until this building was constructed on this campus. He continues to derive some truly significant income from these holdings. He was making a significant amount of money from the group at that time.

Initially I was in Plaza and Los Alamitos, and then as my practice grew a good deal larger, I was then in Los Alamitos full time, as were a couple of other physicians. That building was owned by Dr. Gumbiner as well. So I had a little quarrel with his vision of it.

Indeed, yes, that was a bone of contention, because he was a member of the group and yet he was making substantial income from real estate. I don't think it would have been enough to destroy the group if that were the only thing, but I think when we discovered, the disparity between FHP and fee-for-service, that's when the majority of us opted to split, and we did so.

Initially it was not with a great deal of rancor, but as we got closer to the time of the split, it became much more so. In fact, the board of directors of FHP called me on the carpet. Elton Wisdom, who was a patient and subsequently became a member of the board, threatened me with all manner of dire things if I opted to leave FHP--abandonment [of patients] and all manner of things. Of course, the patients had been

advised three months in advance, with rumor antecedent to that, that the split was going to occur. So it came as no surprise [to the patients] and certainly there was no abandonment involved at all. It was a ploy that was used to try to frighten some of us into staying with FHP. It didn't work, obviously.

Hughes: What happened to physician recruitment after the former partners split?

Lifschultz: That was all Dr. Gumbiner's problem, and I must say, not only was his business acumen quite excellent, his ability to select good physicians was almost unparalleled. We had some really fine physicians and he has subsequently had a number of excellent physicians at FHP. One of the things that I think kept FHP from growing as swiftly as it might have, and it's just my personal opinion, was that Bob did not get along well with doctors. Not just the physicians in our group, but in the medical community in Long Beach in general he was not well regarded.

Hughes: For what reasons?

Lifschultz: He's a very acerbic and abrasive individual. I think that was probably the major thing. And possibly as a corollary, his skill as a physician came into question in some areas. He was not well-liked, especially in the citadels of the good old boys--and they do exist--Long Beach Memorial, Long Beach Community Hospital and St. Mary's. The halls of power in those institutions were not very pleased with Dr. Gumbiner.

Hughes: What factor did the concept of prepaid group medicine play in that displeasure?

Lifschultz: Oh, that intensified it. Their feelings relative to him far preceded prepaid medicine. When I joined him I was a little taken aback when I would go to some of these institutions and mention that I was in association with him. I got--certainly not universally by any means--some rather unpleasant feedback from some of the docs.

It's interesting that in recent years Bob has been pleased to tell me that these same people who used to deride him and scorn him have been going out of their way to be pleasant to him, to consult him, and to try to draw him into relationships, which I can well imagine would be very pleasant. It's a real vindication.

Hughes: Well, did you have any problems with him as a personality?

Lifschultz: Yes. He is abrasive, and very much a one-way kind of guy. His way was, to his mind, the only way. We had our differences. I would say that we in general had a better relationship than he had with probably anyone else in the organization. We were at his house with some degree of frequency. And Dodie, his wife, came to see me at the time that the split was going to occur, and begged me to stay, because she said that he really had not succeeded in building a group until I joined. This is not self-serving; this is what she said. People would stay with him for a bit and then they'd leave, usually in an acrimonious fashion. He and I got along reasonably well. It was after I joined him that the group began to grow, and it grew fairly rapidly. A number of the people were added in the two to three years after I joined, and that was long before FHP came into existence.

Reactions to the Idea of Prepaid Medicine

Hughes: Was prepaid group practice a barrier to recruiting physicians?

Lifschultz: We really had our group at that time. We didn't really recruit. Perhaps we had one man come in, Ken Morrison, who was an FP [family practitioner]. He stayed with us a year or two, no more, and left to go into an ENT [ear, nose and throat] residency. Everybody else, as I recall, was in the group before we initiated the prepaid plan.

Hughes: After the schism in 1966, there had to be recruitment.

Lifschultz: Oh, yes, substantial. Bob really had to start essentially from scratch. He had the three months that we had given him to begin his recruitment, and he did so. As I say, from all I have heard, he in general recruited some excellent people. As with any other organization, some of them were not that good and they didn't last. But by and large, the majority I know were always well thought of, because I had patients in common.

Even though Retail Clerks and the school district were new to us, the majority were fee-for-service patients whom we converted to FHP. So it wasn't as if we had brought in a huge group of new patients.

Hughes: How did the physicians accept the idea of prepaid group practice?

Lifschultz: With some reservation, I think. No one dug in his heels and adamantly refused to go along with it. I have no question, some of them were not entirely happy about it, especially since it reduced their income. I had the largest practice, and so it didn't affect me as profoundly as it did some of the others, especially some of the newer men.

Hughes: What was organized medicine saying about prepaid group practice in the 1960s?

Lifschultz: Very unhappy, very unhappy. This was a threat to the status quo. It raised the specter of "socialized medicine" and the dislike that Bob had experienced previously I think was markedly intensified.

Hughes: Did they see prepaid group practice as a threat to their practice?

Lifschultz: Well, I don't think they saw it as a threat to their practice as much as they saw it as somehow a breaking of the old boy code, the samurai code. It was just something that one didn't do. Most of the people in Long Beach were so entrenched and had been around so long that I don't think they really felt terribly threatened by it. I don't think they had the vision, really, to worry about it, to see what it might well become--not just FHP, but the whole factor of prepaid medicine, which amusingly enough, a large majority of them have now embraced in one form or another. The blue HMOs--Blue Shield, Blue Cross, Cigna--a large number of them now have participants who were the same people to whom Bob was anathema in the old days.

Hughes: Was there social ostracism as well?

Lifschultz: Bob never was a member of the "in" group. I don't think he was ostracized. There were a lot of people who admired him for his social conscience even though they disliked some of his other attributes. He was quarrelsome, he was abrasive, and a number of people accepted him despite that because they did admire his courage and adherence to his principles. So yes, I would say there were people that he knew from the old days, and most particularly, specialists to whom he referred patients. In the private practice of medicine the specialists continually curry favor in one way or another [from referring physicians] and manifest pleasure at the referrals that they're getting, which are indeed their lifeline. I think it was those people who did not ostracize him. Anybody who wasn't getting anything from him was quick to dislike him.

Hughes: Did this extend to organizations such as the county medical society?

Lifschultz: Yes.

Hughes: Was he a member?

Lifschultz: I'm trying to remember whether he was or not. I'm not sure that he was particularly pleased with organized medicine. I really don't recall.

Hughes: Were you?

Lifschultz: Yes.

Hughes: Did you ever run into any trouble when your background came out?

Lifschultz: Yes, there were people who were not pleased with me because I was associated with him. But it never impaired any of my personal relationships. I was vice chief of staff of several hospitals and head of the local academy of family practice. They would make comments.

Hughes: More directed at his personality than at the concept of prepaid group practice?

Lifschultz: Yes. I think the more successful FHP became, the greater the hostility engendered towards Dr. Gumbiner.

Hospitalization

Hughes: You of course didn't have a hospital of your own in those days. Was it ever a problem finding hospital beds for FHP?

Lifschultz: Yes, it was initially. I can't recall that we ever had to do anything drastic, but there were several instances where I think we had occasion to use hospitals that we wouldn't ordinarily use. Hospitals like Memorial and the others that I mentioned were not enchanted. They were delighted to get our fee-for-service patients. They wouldn't capitate initially, nor would the super-specialists capitate until a certain period of time had gone by. I think a large problem was that the super-specialists were very reluctant to go along until they saw the light.

- Hughes: It was a long time--1986--before FHP had its own hospital.
- Lifschultz: Oh, yes. No, I was speaking of the days when we were together. I really can't give you any kind of cogent information about the period from 66, when we split, to 83, when I returned to FHP.
- Hughes: When you returned in 83, was the idea of becoming a hospital-based operation in the wind?
- Lifschultz: Yes. It was certainly being talked about. We were using other hospitals and there was a lot of capitation, but it was a very expensive situation. And it still is. When the paramedics take our patients to other hospitals or when our hospitals are full and we have to send patients to some of the neighboring fee-for-service hospitals, that kills FHP. We pay substantial sums to outside hospitals because patients run up five to ten thousand dollars in a matter of a day or two.
- Hughes: And there's not much that FHP can do about it.
- Lifschultz: That's right. Pacifica is one of the more excessively priced hospitals, I would say, and unfortunately it's one that the paramedics have to use. If one of our patients is taken to Pacifica with chest pain, that's ten thousand dollars before he's shifted. Pacifica gets everything--more, I think, than they would do on a fee-for-service basis.

Private Practice, and Other Activities, 1966-1983

- Hughes: So you left in 1966, and what did you do?
- Lifschultz: I continued in private practice [1966-1976], as did everyone except Dr. Gumbiner and Charlie Eubanks. Four of us remained together as a group, [Fred] Schultz, [Martin] Bouman, [Roy] Johnston, and me. The first named were also FPs. Roy Johnston was our general surgeon for the original group and continued to do general surgery for our [private practice] group.

In the original group, Ben Gelfand was our gynecologist. Rolf Koenker was our internist-cardiologist. Ted Baird was another family practitioner. As I said, Ken Morrison was a family practitioner. I think that was it.

In any event, the four of us were the only ones who stayed together. The other people went their separate ways, either solo or subsequently went into practice with someone who had been unrelated to our group. I practiced that way, successfully and happily, until I had an MI [myocardial infarction] in '76 of such severity that the cardiologist didn't want me to go back to my very large and busy practice--lots of nights, lots of weekends, lots of hospitals. He said, "No more."

I had been teaching in family practice residency programs at Long Beach Memorial [Hospital] prior to that. I'd give an afternoon or two a week. I continued doing that even after I left the practice. Then I ran a travel agency, which I had had for some time, and traveled like crazy. I retired before I retired. [laughter]

I missed the patient contact; I truly enjoyed medicine. So since they wouldn't let me do what I had done before, I thought, well, why not see about going to FHP or another HMO and find a position that would have no nights, no weekends, no hospital. And that's what developed.

Return to FHP. 1983

Lifschultz: When I returned, I saw Dolores in the elevator at Plaza when I came in and she was delighted to see me--astounded probably. I was called to an appointment with Dr. Gumbiner, who hastened to let me know that yes, he was happy to see me as a practicing physician, but that I shouldn't anticipate getting into the administrative end, which was fine, because I didn't want the administrative end.

Hughes: Why did he say that?

Lifschultz: I really am not sure why he said it, but I think perhaps to say in essence, "I like you; you're a good doctor; I'm happy to have you back; the patients liked you. But don't anticipate having a role at the higher levels of this organization." At least that's the way I interpreted it at the time, and I understood that. I certainly didn't expect to be greeted with open arms as far as having a role as a prime mover in this organization.

Hughes: Do you think this was a form of chastisement for your original break with FHP?

Lifschultz: For my defection?

Hughes: Your defection, that's a good word. [laughter]

Lifschultz: Maybe. I thought about it in passing, but it didn't bother me.

FHP Physicians

Hughes: What was your impression of FHP when you returned in 1983 after seventeen years?

Lifschultz: I was not unaware of what had been happening because I got a lot of information without ever asking for it from patients who had left FHP and had come to see me, people I had known who worked for the organization, and some who were still working for FHP. So I knew both of the growth and the ongoing problems FHP was having. Part of the problem, as I think I started to say earlier, was that Bob didn't like doctors. He had a genius for recruiting excellent physicians, and then he didn't give a damn about them. If they didn't like the parameters that were set, "Let them go! We'll hire somebody else." Which I think was rather shortsighted, because it costs a heck of a lot of money to recruit good physicians, which you lose each time they go. What's more, you're putting somebody out into the community--because many tend to stay in the community and prosper--and they are a voice against the organization. So it didn't make sense to me.

Shortly before I rejoined FHP, there was an attempt by a number of physicians within the organization to unionize the physicians within FHP. Anathema! Nothing could have more infuriated top management, most particularly Bob. The thought of unionization just turned him green. And there was actually a vote. The NLRB [National Labor Relations Board] never counted the votes. By going to court, FHP managed to have the physicians classified as administration, as executives, so they could not be unionized. But it gave FHP a sufficient scare so that suddenly physicians' salaries started coming more into line with the industry as a whole. I've been told this by people who were part of the organization at the time, and salaries certainly did go up.

Hughes: Salaries hadn't been competitive before that?

Lifschultz: No.

Hughes: Why then did physicians join FHP?

Lifschultz: The retirement program has always been good. But it's kind of pie in the sky, because if you are not here long enough, your vesting is zilch and it costs the company nothing. And in the old days, the funds that were in the pension plan were then redistributed to people who invested within the pension plan, rather than reverting to the company. So the people who were well entrenched did very, very well.

Hughes: Was noncompetitive salary one of the main gripes?

Lifschultz: Salary was one of them.

Hughes: What else?

Lifschultz: The other gripes? Physicians are, rightly or wrongly, accustomed to being treated with a certain amount of deference. [At FHP] they were just another employee, the equivalent of a receptionist, of any nonskilled individual within the company. Further, where doctors and nurses have almost always been aligned, in this company they have always been separated. Physicians are by themselves: nursing is a totally separate entity. So that hiring and firing of nurses bears no relationship to the physicians at all. If the physicians are unhappy with a nurse, they have to take up the question with a totally separate area of administration.

Hughes: Was that separation deliberate?

Lifschultz: I think so. I think this is an area in which Dolores Kellett played a role. I'm not sure, but that is the feeling I have.

Hughes: Was she respected by Dr. Gumbiner?

Lifschultz: Oh, yes, very much.

Hughes: So what she wanted, she got?

Lifschultz: Oh, yes. She was Bob's right hand, always had been. And she was good. In a lot of areas she was a pussycat, but she could be a very tough lady. I think this was an area that really concerned her. She wanted nursing to be a separate entity.

Hughes: The staff model itself presents problems, to some physicians, anyway. I know from having talked to some of the Kaiser physicians, particularly in the days when Henry [J.] Kaiser [Sr.] was still around and certainly a potent figure, that there was a great fear of being labeled and being employees of

Henry Kaiser.¹ Kaiser physicians made a big thing about being--

Lifschultz: A separate entity.

Hughes: Yes. The Permanente Medical Groups contract with the Kaiser entities. They were adamant that they were not employees of Henry Kaiser. How did FHP get over that sort of hurdle?

Lifschultz: Oh, because there was never any leeway. This was the way it was.

Hughes: So you didn't come if you didn't agree to the system.

Lifschultz: Yes. It was a very autocratic situation. For example, most physicians are accustomed to having an office, a consultation room, to himself. Never in any of the FHP facilities does that occur. The medical manager of a staff model center has his own office, but no physician has. We are always, in every center, side-by-side at continuous desks, kind of cubbyholed. Maybe anywhere from six to eight or ten desks in a room. It was that way at the Plaza, and it was that way in our office in Los Alamitos, which were the two initial offices.

Hughes: Dr. Gumbiner probably would argue that it was a cost-saving measure.

Lifschultz: Oh, yes.

Hughes: But there are more implications, aren't there?

Lifschultz: Oh, yes, no question. Space and cost. But also, I think it is a reflection. He had his separate office. So it was a statement in a sense: "You are my employees."

Hughes: What about physician turnover in these circumstances?

Lifschultz: It was significant, particularly in the days before the change in attitude and the change in salary, but the change in attitude more. That's when the group really started taking off, as I recall it.

Hughes: Do you know approximately the year?

¹See the twenty-volume series, History of the Kaiser Permanente Medical Care Program, Regional Oral History Office, University of California, Berkeley.

Lifschultz: It would probably be about '84 to '85.

Hughes: So just after you'd come back.

Lifschultz: Yes, within the year or two following that. Yes, it grew, and certainly a factor was the development of the Senior Centers, which of course are proving to be enormously successful to the company from the standpoint of remuneration. I think they are a very large portion of the company income now, particularly since the recession. The company is very dependent on the Senior Center incomes.

Hughes: And the fading out of the Medi-Cal population, which at one point I read accounted for a third of income.

Lifschultz: Was it really? I didn't realize it was ever that large.

Hughes: I can't tell you for how long. But there wasn't too much competition in the early days.

Lifschultz: No, I'm sure. [laughter] There weren't too many private physicians who enjoyed that kind of work.

Hughes: You're telling me things that I haven't heard from anybody else.

Lifschultz: Yes, I debated. In fact, I asked Colleen [Bennett] how frank I should be, and she said, "You've got to make up your own mind." I must stress to you that if it sounds as though I'm saying these things in rancor, I'm not.

Hughes: No, I can hear that you're not.

Lifschultz: I'm fond of this guy [Dr. Gumbiner]. He confounds a lot of people in that when there are company functions, parties and the like, most everybody in this company shakes in fear when he comes around. He is a true éminence grise. [laughter] But he comes up, greets me warmly, sits down, talks to me. A lot of the higher administrative types say [in nasal tone], "Who the hell is he that the Master should be talking to?" I must admit, I kind of get a kick out of it because I'm just a worker in the pits.

Hughes: He obviously appreciates your past relationship.

Lifschultz: We go back a long way, and played a lot of two-man volleyball together.

- Hughes: I think it's significant that he selected nine people to be interviewed for this series, and you are the only physician.
- Lifschultz: That's interesting, because there are some physicians--they don't go back as far as I do--who have been with the company for a long time. Like George Kimbrough, who was in the freedom marches with him. Both George and his wife [Laura] have been physicians with the company for a long time.
- Hughes: They were the husband-and-wife team that was brought in right after the 1966 denouement.
- Lifschultz: Yes.

Controlling FHP Medical Costs

- Hughes: What about means to control costs? I've heard about a utilization committee and a pharmacy committee. Do you have anything to say about them?
- Lifschultz: Oh, yes. Utilization has done a lot of swinging. They've gone from being enormously "gatekeeper" without a key to being somewhat more rational. It can be enormously frustrating to deal with some of the entities. Utilization had eased up a great deal. If you felt a patient really needed something, then the patient got it. Just in the last five to six months, we have gone back to the point of obstructionism.
- Hughes: Is that because of new people coming in?
- Lifschultz: Well, old people restored to their jobs. Dr. Long Dang is a very nice guy. (I worked with him before he went into administration.) He was a neurosurgeon in Vietnam who was doing family practice with us, a penultimate company man and survivor, which he had to be to survive Vietnam. He is another one with whom I have warm relations, both he and his wife. But he is inflexible. The company says, "You don't let this happen," and he doesn't let it happen, regardless of circumstances. He was with utilization from about '84 for about three to four years and then moved on to other things. They moved him back in the recent past. It's bottom line time. The company is really trying to retrench because of lowered profits and the way things seem in the marketplace with FHP stock.

FHP--Present and Future

- Hughes: Why isn't FHP doing as well as some of the competition?
- Lifschultz: Well, we're building hospitals, for one thing. They spent a lot of money on hospital one and now on hospital two. I think pharmacy had started to cost them, and they've made some changes in pharmacy.
- Hughes: Is there still a formulary?
- Lifschultz: There is still a formulary, which they will allow you to leave if you can prove that there is a need. That has not been a big problem. The big problem for most of us is getting things done. In the prepaid situation one has to accept the fact that things are not done as expeditiously. I'm not talking about emergencies. Emergencies are taken care of urgently. There's no question, the level of care is good. But there is a protracted wait for some studies.
- Hughes: Why is that?
- Lifschultz: Because there are a lot of people that need the studies. FHP doesn't have the capacity. We're taking in a lot of seniors, many of whom are quite ill. That's the reason they come to FHP. In spite of all the talk about health screens and yearly physicals and that sort of thing, that's not why they join. They join because the cost of their medications is bankrupting them. They can't afford to see physicians on a private basis. That has become, to my mind, ludicrous. As a former private practitioner, I think some of the fees that are charged are unconscionable. I've never been a crusader in that regard, but how can people pay them? I think the American medical community has sowed the seeds of its own destruction and will reap accordingly.
- Hughes: What do you think is the future of FHP?
- Lifschultz: Oh, I think it will grow. I think another thing which has affected income has been the fact that we were on hold. With HCFA [Health Care Finance Administration] we could not recruit seniors for a time because there were alleged infractions of recruiting in marketing. We were on hold for six months or something like that. So we could not recruit; we could not sign up any seniors.
- Hughes: What was behind that?

- Lifschultz: There were allegations of fraud carried out by our marketing people, which were never proven.
- Hughes: Who was alleging this?
- Lifschultz: HCFA, and private practitioners as well.
- Hughes: Yes. [laughter]
- Lifschultz: They seized the opportunity, and lawyers also seized upon it. Since seniors were such a substantive part of the corporate income, when you couldn't recruit--. Seniors die at a faster rate than your commercials do, in spite of excellent care. You've got people in their seventies, eighties, and nineties. They do pass away even with the best of care.
- Hughes: What sort of a moratorium are we talking about?
- Lifschultz: Oh, it's over. It just finished.
- ##
- Lifschultz: Once recruiting has gotten up to speed again, I think income will improve. And once the hospital is done and some of the costs of that pass, the balance sheet will look good.
- Hughes: What is your opinion of the quality of medicine practiced at FHP?
- Lifschultz: I think it's very good. I think it is probably better than it may have been in the years subsequent to the break. Again, I can only tell you what I have heard. In private practice you only hear the bad things. But I had some patient feedback, and some of the care might not have been as good as it could have been, but I think the care now is excellent. I would have no qualms about having any of the people that I work with care for me.
- Hughes: Do you have anything more that you want to say?
- Lifschultz: What is the purpose of your study?
- Hughes: Well, it's to capture as much of the history of FHP as we can, because a lot of contemporary history is not documented. A lot of these things that you have told me are riding around in your head, and I'm sure you haven't written them down.
- Lifschultz: No, I wasn't planning a history of FHP. [laughter]

Hughes: And that applies to most of the people with whom I've talked.

The University does oral histories because it looks upon them as sources of primary information for future research. Now exactly who will look at this information I can't predict, but one of the more immediate users may be the HMO industry itself. I would think they might be interested in seeing how this program got off the ground, what difficulties it encountered. There is a lot of interest these days in managed care. (You're not supposed to say 'HMO' these days.)

In this connection, our office produced an oral history series with twenty Kaiser Permanente leaders.

Reflections on Dr. Gumbiner

Lifschultz: I would not be surprised if there are some significant similarities between Henry Kaiser and Robert Gumbiner. They are both eminently successful, and certainly Bob has been handsomely rewarded, as he merits for the things that he has done. At the time of the conversion from nonprofit to for-profit, there were lots of rocks thrown, because he and some of the "in" group made substantial amounts of money, became multi-millionaires in the process. But hey, he worked for it. Without his single-minded attention to the company, I don't think it would have survived.

Hughes: Could you give me some feeling of what he was like as a family man? He's talked very little about his family.

Lifschultz: I think that a lot of what you see at the business level crept into personal life as well. His kids reflect him, I think, in significant degree. They're scrappers. His [ex-]wife is a marvelous lady. Dodie is a terrific gal, who has the patience of a saint, I suspect. [laughter]

I've always been enormously fond of Dodie. We unfortunately lost our relationship when we split. She was a very bright lady in her own right, had quite a successful career in social service. She was understanding almost to a fault, because he could be very abrasive with her as he could be with a number of other people. Unfortunately, she sustained a very crippling stroke, as you may know. They subsequently divorced.

I had some fun times at their house, and some times when I felt, "God, how do they stand it?" If he talked to me like that, I'd smack him in the mouth. But, really, that's about as much as I can tell you.

Hughes: Did he have much time to spend with family?

Lifschultz: I don't know whether he had to spend as much time away from them. But he spent time with the family. I certainly don't think he absented himself from them. He would go off on his own on occasion; he'd do things he liked to do. He was an enormously active guy. He enjoyed scuba diving, handball, biking. Still does, to the best of my knowledge. Not really a skilled athlete by any means. When we played together on the company basketball team, he was not a great basketball player. [laughter]. As in all things, in sports he was aggressive. That's really about all I can give you.

Hughes: Any parting thoughts?

Lifschultz: Bob was bred to succeed. He had the tools, and he used them to the ultimate. He used them to a degree that I don't think I ever would have been capable of, but then I didn't have his special gifts. I had better "people" gifts than he did, but I certainly did not have the acumen in the field of commerce that he has. I don't think too many people do.

Hughes: Well, I thank you.

Lifschultz: You're very welcome.

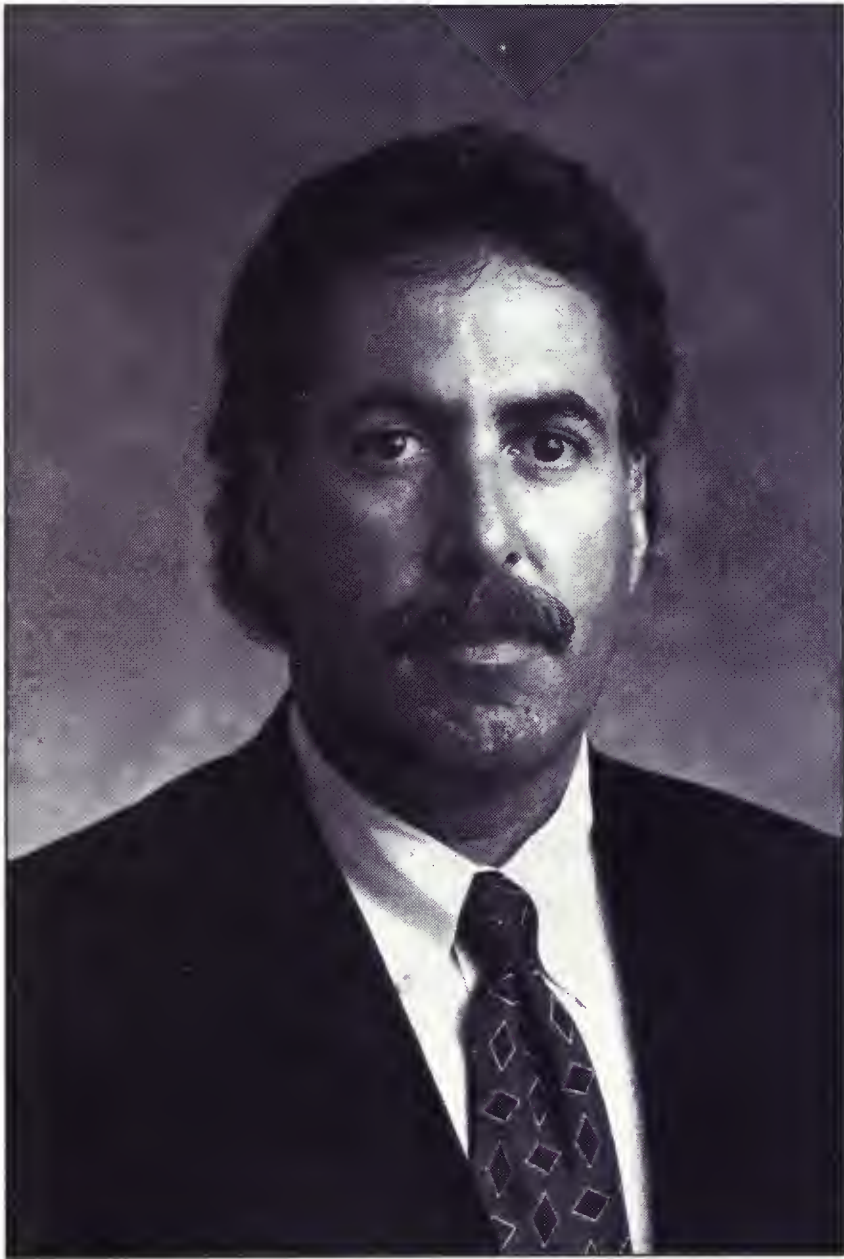
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AN INTERVIEW WITH JACK. D. MASSIMINO

Interviews Conducted by
Sally Smith Hughes
in 1992

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Jack Massimino, 1991

BIOGRAPHICAL INFORMATION

(Please write clearly. Use black ink.)

Your full name JACK D MASSIMINO

Date of birth 3/24/49 Birthplace Pennsylvania (Rochester)

Father's full name JACK MASSIMINO

Occupation Restaurant Owner Birthplace Russelton, Penn.

Mother's full name Columbina (Collic) MASSIMINO

Occupation Housewife Birthplace Russelton, Penn.

Your spouse Janet C. Massimino

Your children Michael & Benjamin

Where did you grow up? Hemet, Calif.

Present community Laguna Hills, Calif.

Education B.A. - California Western Univ.

Masters - American Graduate School International

Occupation(s) FHP - UTARI Region Director

Win Short Assoc. Pres Healthcare Consulting
FHP EXEC VP & COO

Areas of expertise Healthcare

, principally managed healthcare

Other interests or activities sailing, skiing, reading

tennis

Organizations in which you are active Group Health Assn

of America, AMCPA, local politics

Athletic Boosters (Laguna Hills H.S.)

INTERVIEW HISTORY

Mr. Massimino received a master's degree in business administration and the following year joined FHP. In keeping with the company's initiation procedure, he entered the staff management training program. Almost immediately, Dr. Gumbiner appointed him manager of FHP's Fountain Valley Medical Center. According to his oral history, the next thing he knew he was promoted to the executive office as Dr. Gumbiner's assistant. Because Massimino's tenure in the position, 1976 to 1977, coincided with Senator Sam Nunn's investigation into alleged fraud at FHP and four other HMOs, he is able to give a first-hand account of how FHP was cleared of the charges, albeit not without potentially dire consequences for the company. In 1977 Mr. Massimino went to Utah as regional director, following Hal Johnson in that position.

In 1979, he left FHP "to try and do it myself." Doing it himself meant assuming several executive positions in the health field. In 1988, Dr. Gumbiner enticed him to come back to FHP as vice president of corporate development. In 1990 he was promoted to senior vice president and member of the executive management committee, with responsibility for all health care delivery within FHP.

The interview took place on February 20, 1992, in Mr. Massimino's office at FHP corporate headquarters in Fountain Valley. His manner was open and friendly. He was the only one in the oral history series to speak of the FHP Health Care Political Action Committee, of which he has been vice chair since 1988. In the context, he discussed FHP's lobbying activities in Washington, D.C., and his interactions with Group Health Association of America and Kaiser Permanente over certificate of need legislation. He also spoke frankly of his two "blowups" with Dr. Gumbiner, episodes indicating that Massimino is a force to be reckoned with. But the oral history likewise makes clear that he has considerable admiration for Dr. Gumbiner.

Sally Smith Hughes
Interviewer/Editor

October 1993
Regional Oral History Office
The Bancroft Library
University of California
Berkeley, California

X AN INTERVIEW WITH JACK D. MASSIMINO

Background

[Date of interview: February 20, 1992] ##

Hughes: Let's start with where you were born and educated.

Massimino: I was born in Pennsylvania in 1949. That makes me forty-two years old. I did my high school education in Hemet, California. We moved to Hemet when I was about eight years old. I went from there to college. I did my undergraduate work at California Western [University Campus, United States International University] in San Diego; my graduate work at the American Graduate School for International Management in Phoenix.

I became involved with FHP literally out of graduate school. I was one of the people who came in through the staff management training program back in the mid-seventies.

Joining FHP, 1975

Hughes: How had you heard of FHP?

Massimino: It was truly blind luck. I came out of graduate school and went to work for a restaurant chain for a period of about nine months, and hated it about eight and a half months. The LA [Los Angeles] Times, I think, had a blind ad that talked about a recession-free economy, opportunities in the health care field, and I applied. As it turns out, it was truly serendipitous. A friend of mine from graduate school (it's a very small world) was already in the program and was screening résumés. He saw my name and he called me. He said, "Look, I'll tell you about this place."

My wife and I were living in Hemet, and we came down and spent the weekend with him. He told me about this fellow and his vision about the future delivery of health care. That

turned out to be Dr. Gumbiner and FHP. I decided at that point that it would be interesting to go through the process and see what would happen.

Hughes: You hadn't been particularly interested in the health care industry?

Massimino: I was interested but not on the business end; actually, on the practitioner end. I started out as an undergraduate in psychology and had worked with autistic children for a couple of years in a clinical setting. I was doing a master's program in clinical psych with the idea that I would go on and get my medical degree, which was just part of the process. In the middle of it, I just really decided that it was not for me. The highs and the lows of dealing with autistic kids--

Hughes: I can imagine that would be difficult.

Massimino: It was too difficult. So I decided at that point to go to business school and then wound up here. So there was a connection, albeit not very direct.

Hughes: What did you find when you arrived? What year was that?

Massimino: Nineteen seventy-five. I found a very interesting organization, a company that was driven by a fellow who had his view of the world, and that view was pretty direct and pretty directed. The company was young, energetic, very entrepreneurial, in a business that most people thought at the time was near to socialism. We were not a very popular idea at the time.

Hughes: Did that worry you?

Massimino: No. I have always been kind of a risk-taker. As a result, I saw the opportunity side of this business more than the problem side. It just seemed logical to me to marry business and medicine together and wind up controlling health care costs. That seemed pretty exciting.

And the company had a lot going on. The company was small. I can't imagine we had more than twenty-five or thirty thousand members at that time. We had offices down on Spring and Palo Verde in Long Beach, which was where the corporate headquarters were at that time. We had the Central medical facility. We had a facility in Compton because we had a big Medicaid program. That was really the support for the organization at the time. Then we had three centers out here in Orange County. We had one on this campus [Fountain Valley];

in fact, that original center still exists today. We had one similar in Santa Ana and another one, very similar--they were all modulars--in Anaheim.

The interview process was unbelievable for a company this size. You almost felt like you were trying to get a job with NASA or something. [laughter]

Hughes: Who did the interviewing?

Massimino: I think the first manager I interviewed with was Richard Shuck, who was Dolores Kellett's assistant. Dolores was the person responsible for operations within the organization. She was Dr. Gumbiner's nurse back when he was in private practice. She had come along with him and was responsible for developing a lot of the internal systems that we operated with.

I also interviewed with Hal Johnson. I interviewed with Dolores Kellett. I interviewed with Jim Siegal. Jim, who just recently retired, was responsible for professional staffing, which included the staff manager training program. Then I took this unbelievable battery of tests, probably four hours worth of tests--tests we still use today, by the way. The tests are reviewed by Charles Kolinady, Ph.D. Kolinady still is involved with us as the evaluator of the exams.

Hughes: Involved but not an employee?

Massimino: Not an employee, a contractor. He developed the tests for us and we use them as a screen for executives. We have a detailed historical unbelievable pool of information about people who have applied for positions with us and individuals who are with us.

Anyway, I went through that process and by the time it was done, I told John Blake, "My gosh, this is an \$800-a-month job. You would think I was trying to get into the White House or something." [laughter] It was unbelievable.

I did not meet Dr. Gumbiner at that point. I had heard about him. My first job with the company was as manager of the Fountain Valley center. I was in the training program for staff managers. You had to have an MBA [Master of Business Administration] or an equivalent degree. We went into what at that time was supposed to be a two-year training program. The truth of the matter is it was much shorter than that.

First Encounter with Dr. Gumbiner, 1975

Massimino: I heard stories about Dr. Gumbiner and they were all true. [laughter] My first encounter with Dr. Gumbiner was when he came to the campus to do a tour of the facility. I had heard these stories about how he would bring a tape measure with him and he would check the tops of the pictures. We had our own early warning system made up of all the center managers. If he would tour one of the centers, the center manager would find out where he was going next and he would call us so we could get ready for him. [laughter]

Hughes: Everybody panicking.

Massimino: Everybody. This guy, you would have thought he had horns.

When I saw him, he came in late at night, about seven or eight o'clock. We walked around the center, and he did his tour. It was true; he had a different view of the world. He thought pictures needed to be at his eyesight, not at the average guy's. That was the center of the universe. He was a real stickler for detail about the facility, but no worse than anybody else that I had ever dealt with. He cut a pretty wide path and as a result, people were, I think, intimidated by him to a degree. He was a tough guy.

Hughes: Was it common for you to be there that late?

Massimino: It just depended on what needed to be done. I was in a training program and we put in a lot of time. We always had projects in addition to running our centers and taking care of business. It was not out of the ordinary for me to be there.

I went from that position back into the training program. I was out here for about four or five months running the center. I didn't know anything about the medical business; I was running a medical center.

Hughes: Was that what FHP did in those days?

Massimino: Exactly.

Hughes: Just put you in cold.

Massimino: Just put you in and said, "You can figure this out."

Hughes: Was that because they thought that was the best way to learn or did they simply not have an alternative?

Massimino: I think it was a combination of both. Dr. Gumbiner liked to see if people could sink or swim. If you could rise to the top, you were the kind of person he wanted to keep. If you couldn't rise to the occasion, then you were out. In the medical center you had a physician who was responsible for the doctors, a nurse who was responsible for the nurses, and you had an operations person. So you had a lot of support. It wasn't like you just went in there and were expected to know everything about it.

I spent time behind the reception desk, I spent time in nursing, and I spent time in medical records, learning how we did everything. I was the center manager and at the same time that was part of my training rotation. I was learning as I went.

I left this part of the operation and went back to the corporate headquarters at Plaza at Spring and Palo Verde and spent a considerable amount of time going through finance, claims, marketing, and sales, learning about how the company operated. When I say a considerable amount of time, that was probably about another month to two months. Then the next thing I knew, I was Dr. Gumbiner's assistant.

Assistant to Dr. Gumbiner, 1976-1977

Hughes: How do you explain that?

Massimino: Again, luck of the draw. I was probably the most senior person in the training program. I had been in the company about eight months. Hal Johnson was his assistant prior to my promotion. We had just done a merger with Utah and as a result Hal went to Utah so there was an opening for Dr. Gumbiner's assistant. There I was. So I became his assistant.

Hughes: You had no prior connection with Dr. Gumbiner except fleeting encounters?

Massimino: Not a lot of contact. Certainly not a lot of personal contact. But I will tell you that during this time period, he and I spent hours that seemed like months together. We went through a pretty tough time in the organization's history when I was his assistant. We were investigated by a senate subcommittee on Medicaid fraud and abuse. The state of California filed a lawsuit against us. It was an unbelievable time. Those were the days when my mother would call me and say, "Who are you

working for!? What kind of company is this?" [laughter] She was convinced that I was really in serious trouble.

Hughes: What about those charges?

Massimino: There were a variety of investigations of Medicaid going on. A lot of it dealt with fee-for-service billing where physicians were bringing Medicaid patients in and then overbilling for services that were never provided. We were in the prepaid side of the business, and there were questions as to what we were doing with our money, because we were a nonprofit organization, and the relationships between certain partnerships that were developed to build facilities. As a nonprofit, we didn't have access to a lot of capital. As a result, the doctors and managers within the organization put up their own cash to build some of the centers or buy property and arrange for leases back to the company.

Sam Nunn, who was a new senator from Georgia, started a senate investigation into the whole Medicaid issue. The basis of the investigation was a GAO [General Accounting Office] report that was issued in about 1975. It was in that time frame because in 1977 I was in Utah. We got involved in 1976. Dr. Gumbiner went back to Washington and testified. As a result of his testimony and the allegations that were raised, we had to prepare a response.

It was my responsibility to put together all of our responses. I actually had all the secretaries take a similar kind of tape and go through and type it up for us, back before we had PCs [personal computers], so that we could see exactly what we had to respond to. We put together a team and that's when I really spent a lot of time with Dr. Gumbiner because we went through the files. I learned a lot of the history of the company during those days.

It was a fast time for me. I was twenty-five years old. I was shuttling to Washington and up to Sacramento, because we had two fronts going. We were able to resolve all the problems associated with us. We got ourselves carved out of the report and out of the investigation as a result of our response. In fact, we filed two or three telephone books worth of response.

Hughes: That essentially was the end of that?

Massimino: That was the end of it. We had some negotiations with the state of California. There were a lot of allegations going back and forth. We had a physician who had worked for the company, was fired, had gone to an investigator, given him some

half-truths--which was really to our benefit because they were easy to refute. The investigator hadn't done a very good job of following up on the half-truths and so we were able to take care of business.

Dr. Gumbiner certainly knows this better than I do: we had to make some adjustments with regard to ownership of property to satisfy the state of California because as a nonprofit, they didn't want to allow self-dealing. So we ended up doing trades where the company would buy a piece of property and trade that piece of property for the property where the facilities were located, to take the partners out of the relationship.

As a result of that, Dr. Gumbiner and I probably became as close as you could come with him in the organization at that time. In fact, I remember it was Christmas and he called me in and he said, "I'm going to give you a bonus." I said, "Boy, that would be great." He told me how much it was going to be and he said, "I'll send the paperwork through." The next day, the payroll person came up. (Everything was manual in those days.) Her name was Nancy; I don't remember her last name. She said, "I don't know how to handle this." I said, "What do you mean?" "He's never given anybody a bonus before. How do we deal with this?" "Just give me a check; that will be fine." [laughter] I had been with the company just about a year at that point and had been through some pretty interesting events.

Hughes: Did you figure out what makes Dr. Gumbiner tick?

Massimino: I think he is a driven guy. I think he has his view of the world and his view of health care. I have learned a lot about him over the years, because he also has this unbelievable humanitarian side to him, which most people don't recognize. He was organizing the right to vote in Mississippi back in the sixties. People just don't know that about him. The company was involved in the Medi-Cal program because he thought there was an obligation to provide care to the indigent, and there was an opportunity to make some money at the same time.

Hughes: The care of the needy really was a legitimate concern of his?

Massimino: Absolutely, and still is today. I don't know if you are aware of all the programs we do in the Northern Mariana chain. Our foundation sponsors a lot of health care programs to the islands where they just don't have access to health care. We've set up dispensaries; we've funded boats that take health care providers or professionals from island to island to

provide care. That's always been an issue with him and I think most people miss that when they talk about him.

Hughes: Well, it certainly doesn't seem to fit the first impression.

Massimino: Exactly. He is a dyed-in-the-wool Democrat. Probably could have been in a union at some point. If he had been around in the early twenties, I suspect he could have been an organizer. So that is an interesting side of his persona that I think most people miss, because they see him as this very driven, out-front business type.

The good news about him is that he is single-minded. I have met several businessmen in my career who are very similar. They are all individuals who started companies that have grown significantly over the years. They started them from scratch and they were driven individuals. As a result, they give up a lot. They dedicate themselves 125 percent to their business and so they miss some of the other things in life. Then they try to capture that later on in their lives.

Hughes: Which Dr. Gumbiner seems to be doing now.

Massimino: Yes, he clearly is. It seemed to me over the years, he always sprinkled a little bit of that in. He would try and work in time with his family and take his boys hiking and camping and things of that sort. But it was always the way he wanted to do it. There was not a lot of flexibility associated with it. So he tried to balance it, I think, but it's a tough thing to do when you are trying to take a company, not just a company that people know about, but a company in a brand new industry that certainly didn't have a lot of support from the business community. It had some governmental support but that was almost as much a drawback as it was a support at the time.

Managed Care as a Concept

Hughes: How was organized medicine responding to FHP?

Massimino: Not very pleased with the whole concept of managed care, primarily because our objective was to reduce lengths of hospital stay, get rid of the waste in the system. As Dr. Gumbiner would say, "We wanted to wring the waste out of the health care system." I think that a lot of the changes that you've seen over the years--people not being admitted on Friday for Monday surgery, the development of outpatient surgical

facilities, referrals, prior authorization, preventive care, working on the front end as opposed to the back end--all of those things really were spawned by the managed care industry. I think the industry has done a heck of a lot in terms of changing the way medicine is practiced in those areas where you've seen pretty significant penetration and market share development by managed care companies. Those were not easy things to do in the early days.

We had to explain to employers why they would want to get involved with an organization such as ours. We had a two- or three-level sale that we had to make. First we had to sell a broker who was the intermediary between us and the employer. Then we had to sell the employer. Then we had to sell the employees, just to get someone to select our health plan. In California, we were a little luckier because Kaiser had been here a long time. Although there was the good news that people knew about Kaiser, there was the bad news that they didn't like what they called assembly-line medicine.

So there was both good and bad that came out of the Kaiser history. We were competing with insurance companies. Organized medicine would say things about us, about the quality of the doctors that we recruited. For example, that they obviously couldn't be good doctors because if they were, they would be in fee-for-service. Our comments always were, "The doctors who are in fee-for-service are probably the ones we rejected." [laughter]

Hughes: That made you popular.

Massimino: [laughs] Organized medicine was a real threat to the industry early on. It's changed over time. Business has become more and more enamored with what we're trying to do. As a result, organized medicine has had to adjust. Today it is easier for us to recruit family practice physicians than it ever has been. Doctors are coming out of medical school with the idea that they would like to make a career in managed care as opposed to setting up their own practices. That was not the case twenty-five years ago, I can tell you that. Managed care was a totally new concept. So we spent a lot of time educating, selling lifestyle, things of that sort, when we were recruiting physicians.

We had a very high turnover rate. Doctors would come into the company, they would be here for a year or two, and then they would be gone. Part of that was just the whole organized medicine concept. It was tough for a physician to belong to an HMO and go to the local country club. That has changed

dramatically. Our turnover rate was as high as 40 or 50 percent a year in those days. Today our turnover rate is about 10 percent.

Hughes: There were also internal stresses, I would think. The idea of a physician being an employee, which in a staff model HMO a physician is, is not the way medicine in this country has been practiced. So I can see how that would be a problem for many physicians.

Massimino: No question about it. In the early days, we recruited a lot of physicians who were retiring, who were in their fifties. We got a lot of physicians who had been practicing in the military. We didn't attract a lot of young physicians in the early days, primarily because they were all full of themselves and ready to get out and really take a look. But you are absolutely right. Doctors would get in here and not have an understanding [of our system]. We had protocols and processes that they had to follow. They wanted to do it their way; we wanted them to do it our way. So there were internal conflicts.

The ones who adjusted did very well with us. They stayed for years. Henry Masino, who is out in our Compton facility, I think is retiring, if he hasn't just retired. He's been with the company twenty years. George Kimbrough and his wife are family practitioners. They joined the company about the same time I did. I came in 1975; they were here in 1976, 1977. George and Laura have been with us forever. They are personal friends of Dr. Gumbiner's.

Hughes: Is there an FHP physician "type"?

Massimino: No, I don't think so. Not today. When I started, yes, there probably was. They were probably leaning more towards people who were ready to retire, wanted to get out of the hustle and bustle of private practice. Today I think that the FHP physician is no different than the fee-for-service physician. I think they are identical. We have as many young doctors as we do doctors who are in their forties and their fifties who have sold their practices and still have twenty years left to practice out in front of them. We have doctors now who are looking at FHP as a career as opposed to a job, and I think that is a significant change in the whole program.

The other thing is that the company has evolved over the years to the point now where we have many more doctors under contract than we even have on our staff. I'm not even sure of

the total number of doctors that we contract with around the various states that we do business in.

Hughes: Why would FHP contract?

Massimino: We are known as a staff model on one hand. We are also an IPA and a group model. We blend them in what we call our "mixed model" concept. We open new markets with our IPAs and our group model concept. You don't have the big capital intensity that you need when you develop a staff model. As a result we contract with a lot of physicians and hospitals in the various states where we do business.

Utah, 1977

Hughes: You mentioned that after being assistant to Dr. Gumbiner, you went to Utah to become regional director. I would like to hear about that venture, too. Utah was when?

Massimino: Nineteen seventy-six is when we merged with Utah Group Health Plan.

Hughes: When did you go?

Massimino: I went to Utah in February of 1977. Hal Johnson was there for about nine months. Hal's job was to stabilize things.

Hughes: He was regional manager?

Massimino: He was the regional director in Utah. He had been Dr. Gumbiner's assistant. The cycle was you went through the training program, became Dr. Gumbiner's assistant, and from there, you went out and ran a region. Hal did that. A fellow named Larry Pett did that. Another manager named Bob Mack did that. Bob and Larry were each responsible for Guam at different times. Hal ran Utah. Then I went from being Dr. Gumbiner's assistant to Utah. We were the first half a dozen graduates of the staff manager program.

I went to Utah in February. In fact, I remember very clearly, my wife was eight-and-a-half months pregnant at the time. I had a choice. Dr. Gumbiner gave me the option of either going to Guam or going to Utah. Guam was making money; Utah was losing money. Guam was a long way away to take my eight-and-a-half-months-pregnant wife. Utah was a lot closer

and I figured I couldn't screw Utah up any worse than it already was. [laughter]

Hughes: I love the rationale.

Massimino: So I went to Utah. We moved there in February. My second son was born the ninth of March, so it was pretty close timing. When we moved in, there was three feet of snow on the ground and my wife was a southern California native. [laughter]

Hughes: A lot of things to hurdle.

Massimino: Exactly.

Hal came back from Utah and took over operations in California; he ran the California region.

I remember my first task in Utah. We were losing a lot of money, several hundred thousand dollars a month. So after I had been there about thirty days, I decided what we really needed to do was have a reduction in force. We had to change the overall strategy for the region. It was principally a welfare program. We had a couple of commercial accounts but it was truly a welfare program.

We had two facilities: one very nice facility in the southern part of Salt Lake, in the valley; and one facility out in the central valley which was the old county hospital that was converted to medical space. We did a remodel there but it still was the old county hospital location. As a result, we had an image of being a low-income welfare program, which was very true. Ninety-five percent of our members were in that category.

I had to do a reduction in force, which I did. We ended up laying off sixty or seventy people, which was a big number compared to the number of employees that worked in the region. I will never forget: this was one of my first real run-ins with Dr. Gumbiner. I had been there about three or four months and I had taken all this heat doing the reduction in force. We had made a lot of sweeping changes. We made the losses go from \$200,000-\$250,000 a month down to \$30,000-\$40,000 a month. We made some pretty dramatic changes in the operation of the business. In those days, those were very big numbers.

I got a memo from Dr. Gumbiner that was unbelievable. He wanted to know how I could possibly have taken over a break-even situation and in such a short period of time managed to lose so much money, which was the accumulation of what we had

lost from the time we had taken it over to that point, several million dollars. Normally, I am a pretty controlled guy, but I just went ballistic and fired off this memo, explaining to him exactly what had happened and suggesting that he should get his facts straight before he came after me like that.

My secretary took it to our medical director, Nick Danforth, and said, "He really shouldn't send this out. He's going to get fired over this memo." [laughter]

##

Massimino: Nick told me I should take that memo, put it in my desk, and let it sit there for a couple of days. I agreed. I put the memo in my drawer. A couple of days later I pulled it out, read Dr. Gumbiner's memo first, got just as mad as I did the first time [laughter], never reread mine, just sent it.

My wife was in San Diego. I called her and said, "I may be joining you. This may not be working out." I told her what I had done. Two days later, I received a phone call from Dr. Gumbiner. It must have been eleven o'clock at night. He always would call at all hours of the day or night. He would be working, would just think of something, and give you a call.

I answered the telephone and he said, as he always does, "This is Robert Gumbiner." I said, "Hello, Dr. Gumbiner." "I'm looking for Jack Massimino." "This is Jack Massimino." [laughter] Who else would it be? He said, "I have just received your memo." I said something to the effect of, "Well, I'm glad you got it." I'm panicked, of course. He said, "It appears I had some bad information." And he hung up. That was the end of the conversation. [laughter]

Hughes: Wonderful! Is that a successful strategy?

Massimino: In dealing with him?

Hughes: To meet force with force?

Massimino: There is no question that in dealing with Dr. Gumbiner, the best way to do it is straight up. Make sure you know your facts. The best way to deal with him is straight up because if he can step all over you, he will. If you stand up to him and show him that you know what you are talking about, then he is a much more reasonable person to deal with. I've always found that that worked very well.

The other thing I've found is that it doesn't make a lot of sense to take him on in a public arena. You can do a lot better one-on-one in dealing with him. There was a time when he was going to be right, irrespective of the position you took. So I found that the best way to deal with him was always straight up. It just worked out better.

At any rate, I was in Utah about three years as the regional director. I gave him notice of my resignation. I was going to leave and go out on my own with some partners.

Confrontation with Dr. Gumbiner

Massimino: I had given notice and we had a planning meeting in Utah. This was the time he and I had our second major blowup. They kept telling me, "You have to come to the meeting. We need your input before you take off." I said, "Look, this won't be pretty." Because in those days, an ex-FHP employee was a bum. There was no socially redeeming value associated with somebody who used to work with the company. And I knew that going in to the meeting.

I certainly didn't want to burn any bridges. That was one of the reasons I didn't want to go to this meeting; I knew it would be confrontational. They convinced me that I should come to the meeting. Dr. Gumbiner, who is perennially late, was also late for this meeting. He is never on time for anything.

Hughes: Tell me about it! [laughter]

Massimino: I tell you, that also drives people nuts.

Hughes: Why is that when he is so efficient with other aspects of his life?

Massimino: I think it used to be part of, "I'm the boss and when I'm ready, I'll see you." Now, I think it's just habit; he just doesn't care. But it drives people crazy, to the point where people start to blow him off. You can't plan your schedule. The days you are supposed to meet with him, it just creates an unbelievable imbalance in your schedule.

Anyway, he was late for the meeting as usual, and we were starting the process and he came in. He wasn't there five minutes and the two of us were just at each other, just going at it. He was telling me that he made me everything I was and

I was telling him I did everything he needed to have done in Utah and if it weren't for me there wouldn't be a program. The other guys were just sitting back watching this exchange.

Finally, I left, which was the best thing to do. I just went home. They continued to have the planning meeting, and then they went out to dinner. (I've heard this second-hand from the guys who were there.) He started to say what a bum I was, he was going to fire me anyway, and I think it was Burke who said, "That's not true. You wanted him to come back to California as the vice president of operations. What are you talking about?"

That night he called me and he said, "Look, let's have dinner." I said, "No. I don't want to have dinner. This is not how I wanted to leave the company, certainly wasn't my intention. The two of us are just too stubborn." He said, "No, let's have dinner." "Okay, you come down here." "No. You come up here." [laughter] "We'll meet someplace."

We probably spent the best three or four hours that I've ever spent with him, talking from soup to nuts about the industry, the company. He was concerned about why I was leaving. I think he thought that it might have been something to do with him. It had nothing at all to do with him. I told him at the time that I thought that he would understand better than anyone the reason I was leaving was because I wanted to try and do it myself. He had done it and I wanted to see if I could do it.

Hughes: And that made sense to him, didn't it?

Massimino: Yes, it did make sense to him. I will tell you this: had we not had that dinner meeting, I wouldn't be here today. There is no question about that. But it was probably truly the best three or four hours of my time with him. It was a real interesting meeting.

Hughes: He was hearing you.

Massimino: Well, I hope so. We were certainly listening to each other for the first time. He must have heard something; otherwise he would never have contacted me to come back with the company.

Hiatus

Massimino: I left the company just a couple of weeks after that and went into the consulting business with some partners. We got very lucky. In a period of about two or three years, we had grown one of the largest health care consulting firms in the country. We were in Salt Lake, Austin, Atlanta, Chicago, and Washington, D.C. We had the most prestigious clients: the Methodist Hospital in Houston, the American Medical Association, American Hospital Association--probably four hundred hospital clients across the country. We did work for the federal government. We had contracts ranging from managing health care facilities in San Diego to distributing birth control in Latin America. We had a lot of fun, to say the least.

We were acquired by a company that wanted to make a big play in the hospital business. It wanted my partner and me to do its development work. We would not leave our firm and as a result, it acquired us to get us to do its work. We then developed this hospital company, took it public, had hospitals in Texas, California, and Florida. We ran that for a couple of years and merged with a group called Republic Health out of Dallas, which was another hospital company, and about doubled its size when the merger occurred.

I had the ability to leave the company at that point. I had a contract called a golden parachute. I was well taken care of and had the ability to go do whatever I wanted to do. So I retired for a while and played a little golf.

Hughes: At what age?

Massimino: This was 1984. I guess I was thirty-five. I took my family and we traveled. I spent time with my children. I learned a very valuable lesson, one that I still adhere to today, and that is that my family is very important to me and I will not under any circumstances jeopardize that. When I was in the hospital business and the consulting business, growing my business, I was gone a lot. I didn't realize how much I had missed until I was home. So I coached Little League, I did basketball, I did all of those things that I hadn't the time for previously. I played golf. I got my handicap down to about a two.

About six months into that, I was just bored to tears. We had built a new home. I had a study that I was using as my office. My wife came in and she said, "Listen, I've just hired a decorator." I said, "Why did you just hire a decorator? We just redid the house." "Well, I want to redo the study." "No,

no. I like it just like it is." She said, "Let me make this very clear to you. I want you out. Get a job, get an office, get a secretary, but get out of the house. You're driving me nuts." [laughter]

So I started doing a little consulting. One of my clients asked me to come in as the president and CEO of their operation, which was a turnaround HMO. It was a disaster so it looked like a good challenge to me. It was in Austin, Texas, which was where I was living at the time. I had been there almost seven years at that point.

Return to FHP, 1988

Massimino: I was about fifteen, eighteen months into that process, when I got a call from Hal Johnson. He said, "Listen, Dr. Gumbiner would like to get together with you." I said, "Fine, have him call me." So he called, out of the clear blue, and he said, "I'll be in Dallas. Can we get together for dinner?" I said, "Of course."

I called Jan, my wife, and said, "You'll never guess who called." She said, "You tell Bob Gumbiner you're not working for him again." [laughter] I said, "Did he call you or something?" "No, I just have this feeling." I said, "Well, he called."

So I went to Dallas. We had a very nice dinner. We got on each other about gaining weight, things like that, and he offered me a job. I told him I wasn't interested, that I had other things that I was doing, but he's persistent. He's a very persistent guy. The chase is as much fun for him as anything. It took us about four and a half months or so to put together a deal that we could both live with and here I am, back in the company.

Since that time, he has changed a little. When I came back, he asked me if I thought there was change in the company. I think he was talking about size. I said, "Yes, the company certainly is a lot larger. It's in a lot more locations. But the company hasn't changed a lot." He said, "What do you mean?" I said, "You still call every shot in the company." He said, "That's not true." I said, "Well, if that's not true, there certainly is a bad impression floating around out there that you are making the decisions."

That was about four years ago. Since that time, he has really begun to wind down his daily involvement in the operations of the company. He retired last year as the chief executive officer of the company but still retains his position as chairman of the board. He is nowhere near as active as he was historically in either the direction or the operation of the company.

I will tell you that people have asked me why I came back to FHP and one of the driving reasons was Dr. Gumbiner. I wanted to have a chance to spend some more time with him because I think he truly is one of the most brilliant men in our business. He was a leader in an industry that didn't even know where it was headed. He took this company, pushed it, pulled it, kicked it and he made it into what it is today. As a result, I think he is truly one of the pioneers in our business. There is no doubt about it. He has an uncanny ability to get to the heart of an issue quicker than just about anybody I've ever come up against. That's a lot of fun. I will tell you the other side of him: he can drive you nuts at the same time. So he is an interesting man to work with.

Hughes: Even though you knew that his days with the company were obviously numbered.

Massimino: They were numbered as an operator. But as chairman of the board, he is still involved. He has a consulting relationship with us so we have the best of both worlds that way. We get to take advantage of his abilities and not have him here day-to-day. [laughter]

Hughes: What year was it that you came back?

Massimino: I came back to the company in 1988.

Maxicare

Hughes: One of the things I wanted to hear about was the conversion from nonprofit to for-profit.

Massimino: I got only very, very peripherally involved in that. The company was going through the conversion process and had decided to go public. During the conversion process, Maxicare, Fred Wasserman, made a play to acquire the company. When that happened, FHP was in a difficult position. Nobody really knew exactly how the Department of Corporations would deal with a

conversion, whether there was going to be difficulty from their perspective.

I called David LeSueur. I don't know if he was in my current position or one step removed but he was one of the senior managers in the company and a fellow that I knew for many years, and obviously somebody you need to talk to because he was here when I was working elsewhere.

I called David and said that I could offer support. In business terms, I could offer a "white knight". If FHP needed some help fending off Maxicare and wanted to stay involved, I could bring a party that had the financial wherewithal to maintain the company and help drive it, although it would be a different circumstance because this was a much bigger company that I was dealing with. That was the limit of my involvement in the conversion.

They didn't have any need for it because as it turned out, the Department of Corporations ruled in favor of FHP.

Political Action Committee, 1988 to Present

Hughes: I noticed that you were vice chair of the FHP Health Care Political Action Committee.

Massimino: Yes. We have had a political action committee for years because of our involvement with federal programs. In fact, Dr. Gumbiner and I went to Washington, D.C., and I leased the office space there and we hired our first lobbyist in Washington back in 1976, somewhere in that time frame. It was before I went to Utah. Today we have a big federal program with the risk contract for the Medicare enrollees. We have some 250,000 seniors that we contract with the government to provide all of their health care.

But in those days, we had the Medicaid program. We had a program for active federal employees. The HMO Act itself was just beginning to shake out. Regulations were being drafted. All that had an effect on us. Dr. Gumbiner again was out in front of everyone and believed that we needed to have active involvement in Washington, D.C., for our industry. As a result, we set up a Washington office.

At the same time we did that, we put together a political action committee internally with our employees. This year I

believe we'll have somewhere in the neighborhood of \$70,000 contributed by our employees to aid in the political process, to make contributions to those congressional and senatorial delegates who support managed care and the programs that we would like to see go forward.

Hughes: The Group Health Association of America wasn't enough to wage this battle at the federal level?

Massimino: No, not enough. GHAA was a fledgling organization back in the seventies. It was just beginning to get its stride. GHAA in those days was really dominated very early on by Kaiser because it was such a large part of the operation. So they set most of the agenda at that time.

Hughes: Which wasn't necessarily yours.

Massimino: Which was not necessarily ours. We had a little different view of the world. Even though we were a nonprofit organization, we always knew we had to make money to stay in business. We sometimes had different directions that we wanted to take the company. We had a different view about regulation. A really simple one, for example, was when the certificate of need law passed. Do you know what that was?

Hughes: No, I don't.

Massimino: Back in the early eighties, the Congress passed a piece of legislation that required all new hospitals and hospital equipment over a certain dollar amount to receive a certificate of need. You had to go through an administrative law process to get approval. You had to write an application and you had to present your application, and there were people who opposed you. There were health planning groups that were developed in each state to devise statewide health plans and they did needs assessment to determine if you needed hospitals here, x number of beds there, or this kind of equipment here. If you were in compliance with those plans, you were able to get approval for your program.

Well, GHAA supported a position that included HMOs in certificate of need. FHP believed that HMOs, particularly HMO hospitals, should be exempt from certificate of need because they didn't bear any relationship to the community at large. Those hospitals were developed for the HMOs' membership. Kaiser opposed that view.

Hughes: Why would it?

Massimino: I really don't know why. It didn't make sense to me that Kaiser would do that, other than that it didn't want other HMOs to get into the hospital business. But that would be a pretty short-sighted view because they would want to develop more hospitals. I really don't know the rationale, but Kaiser opposed it. We supported carving out HMOs and our lobbyist was successful. So that was one of the areas where we parted company with the trade association. Our Washington office really assisted us in that process.

Our political action group also deals on the state level. We have political action committees in every state that we do business in because the state governments are very important to us as well. They are always dealing with issues. State legislatures like to mandate benefits. "Today we'll put the chiropractors in, tomorrow we'll put the herbologists in, and the next day we'll put whomever else in." Those will be benefits you'll have to provide. Every time you get a mandated benefit, the cost of the program goes up. We're always opposing additional mandated benefits that managed care has to provide. We need a legislative group to be able to deal with that.

Hughes: And you have an effective one, you feel?

Massimino: I think we have a very effective one. We are actively involved in the states that we do business in. We've won our share and we've lost our share. You can't win them all, but we've done pretty well over the years.

Board Memberships

Hughes: You are also a member of the board of the hospital. Would you say something about that?

Massimino: I am a member of the hospital board here as a result of my promotion [from vice president of corporate development to senior vice president]. I'm on a variety of boards here now, most of which I don't know anything about. [laughter]

Hughes: Why don't you say something about the ones you do know something about?

Massimino: I am a member of the FHP Fountain Valley Hospital board. We deal with the business of the hospital. We review equipment purchases, expansions, and new programs. Most recently, we

just completed a 125-bed expansion of the hospital, doubling the size of the facility. The board was actively involved in that process. We review the performance of the facility and its management.

Hughes: Are there other boards that you want to talk about?

Massimino: None which would be relevant. As is the case with most companies, there are a lot of boards of closely held companies. Those boards meet and deal with business but it is not really exciting stuff. It's just business.

Matrix Management System

Hughes: Do you want to comment on the matrix system? The famous matrix system?

Massimino: [laughter] You've heard a lot about that. The matrix was developed right about the time I was leaving the organization. It was a concept Dr. Gumbiner was working on. He had read about it. A pretty good theory, actually. When you are a fast-growing organization, which takes young managers like myself and puts them out in Utah and says, "You're responsible for this operation. Yes, you spent two weeks in marketing and a month in finance. Take over Utah," the matrix makes a lot of sense.

The way matrix worked was that I had a medical director in Utah who reported to me. He also reported to the corporate medical director. So there was a direct-line relationship between the corporate people and the regional operators. When we were smaller and we sent a lot of inexperienced--and by inexperienced, I mean just not a lot of years under their belts--managers into the regions, matrix was a very positive aspect.

Today this is a \$1.3, \$1.4, \$1.5 billion company. We have managers who have been here for years who have a considerable amount of experience. Matrix just did not work as well once the company got to a certain size. There is no way a medical director at corporate would have complete understanding of every aspect of the delivery of health care in Utah, Arizona, New Mexico. It just didn't work. So as a result, we phased it out about a year ago.

Hughes: Oh, that recent?

Massimino: Yes. We made that change at corporate. We went to a much more traditional relationship where the functionals here, for example, the corporate medical department, have responsibilities dealing in several areas. Line management is not one of them. They are responsible for technical assistance; they are responsible for strategic planning.

At the same time that we made the change in the roles and responsibilities of the corporate functionals, we also implemented the quality improvement process. Once we did that, we had to have the development of requirements fall somewhere. Those also fall with the functionals so that they develop in conjunction with the regions because it's a negotiation, the requirements that the regions have to adhere to to operate their business. That's another one of the roles that the functionals are involved in.

But I see their primary role as development of requirements. Once they are developed, we are not going to develop a lot of new requirements as we go on, but they will be always upgrading them and improving them. But strategic planning and technical assistance are areas where they really need to focus their attention. What's this company going to look like in the next five or ten years? How are we going to deliver health care in a better, more cost-effective manner? That's how I want them to spend their time.

The regional managers are really focused on running their business. Yes, they do think strategically, but they think strategically about their region or their district. The corporate functionals are really beginning to spread out and think strategically about the company.

Historically, Dr. Gumbiner was a strategic thinker. He laid out the direction and the rest of us were implementers. That was our job. Now it takes about fifty of us to strategically plan. [laughter] I'm being facetious, but it takes a lot more of us than it did in those days. We have developed our strategic direction and we spend a considerable amount of time in strategic planning, thinking about next year, the next five years, and the next ten years for the organization.

Hughes: You have to go, I know. Is there anything more you want to say?

Massimino: No, other than that Dr. Gumbiner is certainly one of the most interesting men I have ever met. I have been around a little and met a lot of other businessmen, a lot of other leaders or

captains of industry. He certainly is one of them. There is no question in my mind about that. I have been on highs and lows with him, but overall I have enjoyed my relationship with him.

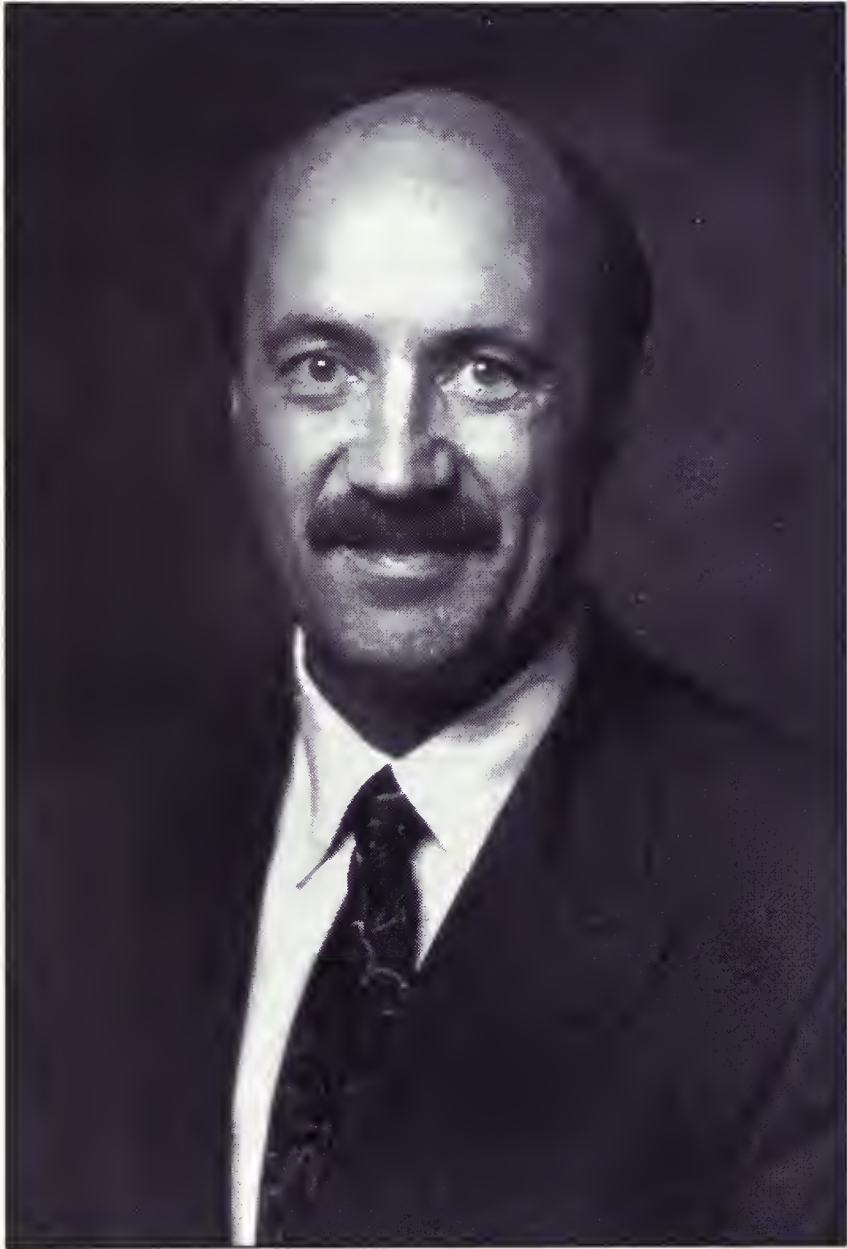
Hughes: Thank you.

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Berkeley, California

AN INTERVIEW WITH RAYMOND W. PINGLE, D.D.S.

Interviews Conducted by
Sally Smith Hughes
in 1992



Raymond W. Pingle, D.D.S., 1993

BIOGRAPHICAL INFORMATION

(Please write clearly. Use black ink.)

Your full name Raymond Wayne Pingle

Date of birth July 10, 1947 Birthplace Los Angeles, CA

Father's full name Arthur Pingle

Occupation Grocery Market Owner/
Real Estate Broker Birthplace Ontario, Canada

Mother's full name Helen Wilkinson Pingle

Occupation Elementary School Teacher Birthplace Pasadena, CA

Your spouse Separated

Occupation _____ Birthplace _____

Your children Camara Pingle; Robin Pingle

Where did you grow up? Southern California

Present community Huntington Beach, California

Education Pepperdine College, 1965-1967; USC, 1967-68; DDS from UCLA, 1968-1972;

Certificate of Management from UCLA, 1981

Occupation(s) Corporate VP, Health Care Delivery Systems Support; Corporate VP,
Claims; Corp. VP, Dental Affairs; Corp. VP, MIS; Regional VP,
IPA Senior Plans; Corp. VP, Medical & Provider Services; Corp. Director,
Associated Services; Dental Director; clinical dentistry

Areas of expertise The application of computerized systems in the delivery
and management of health care, general HMO management, medical and dental
health care management, claims management

Other interests or activities Environmental activities, personal computers,
hiking

Organizations in which you are active Sierra Club (Past Chair of the National
Population Committee)

INTERVIEW HISTORY

Ray Pingle is a dentist who was included in the oral history project partially because of his contributions to FHP outside the field of dentistry. He received his DDS degree from UCLA in 1972 and started working for FHP at its Compton, California, facility directly after dental school.

As Dr. Pingle related, it was highly unusual for an HMO to offer dental coverage at that time. Initiation of the program was prompted by FHP's need to comply with requirements for participation in a pilot prepaid Medi-Cal (the Californian counterpart of Medicare) program. Two years later, in 1974, Pingle was made dental director. Shortly afterwards Dr. Gumbiner asked him to set up a malpractice prevention program which eventually saved the company millions of dollars.

In 1978 Dr. Pingle was promoted to corporate director of associated services, which included dentistry, optometry, pharmacy, health education, mental health, and the department of human resources. From there he moved quickly through a variety of executive positions which he describes in the oral history. He is currently vice president of health care support systems and vice president for claims.

Dr. Pingle was interviewed on February 20, 1992, in his office at FHP's corporate headquarters in Fountain Valley, California. As the only dentist in the oral history series, his view of dentistry at FHP is course valuable. But of equal importance is his discussion of the responsibilities of his other positions, none of which are discussed by the other interviewees in the project.

Sally Smith Hughes
Interviewer/Editor

October 1993
Regional Oral History Office
The Bancroft Library
University of California
Berkeley, California

XI AN INTERVIEW WITH RAYMOND W. PINGLE, D.D.S.**Education and Arrival at FHP, 1972**

[Date of interview: February 20, 1992] ##

Hughes: Start, please, with where you were born and educated.

Pingle: I was born in Los Angeles in 1947, and I was educated for two years at Pepperdine College in Los Angeles, one year at the University of Southern California, and I received my D.D.S. from UCLA in 1972.

Hughes: You came to FHP right after graduation?

Pingle: Yes. Straight out of dental school I started working as a dentist for FHP at its Compton facility [1972].

Hughes: Now why FHP?

Pingle: Well, I needed to start making some money and I wanted to find out whether I should go into private or group practice. I wanted to go to a group first to learn a little about how to manage the business of dentistry. I chose FHP because it had just started a dental department about four months before I started working for FHP, and I thought, "Here's this HMO just starting a dental department. I'll be able to observe or maybe even participate in how the dental department is set up."

Hughes: FHP was somewhat unusual in the HMO industry in having dental coverage?

Pingle: Yes, it really was very unusual. As a matter of fact, Dr. Gumbiner used to talk about how FHP was a pilot for a prepaid Medicaid program. One of the requirements for participating in that program was that you had to provide dental services. I think Dr. Gumbiner may have had some other alternatives on how he chose

to provide those dental services to meet that requirement. But he's always been a strong believer in vertical integration and decided he wanted an in-house staff model dental department. So he worked with a community dentist, Godfrey Parnell, that he knew on a personal basis. Dr. Gumbiner brags about how, within sixty days, he set up a dental department.

Hughes: What did you think of it when you arrived?

Pingle: Well, it had a nice facility, brand-new equipment. Some of the systems were set up like a medical office and didn't work at all, so we had to work on how to straighten that out. But it was a good organization and it had a variety of patients to take care of. As dentists we were given a lot of latitude in how to practice dentistry. There was an emphasis on quality. One of the concerns I had in working for any group dental practices was, is this going to be a mill-type of operation? But it wasn't.

Hughes: You could practice dentistry the way you wished.

Pingle: That's right.

Director of the Dental Department, 1974-1978

Hughes: Why were you made dental director--very quickly, two years later?

Pingle: Well, yes. The dental director that FHP started out with for several reasons really didn't work out, and so Dr. Gumbiner terminated him. It was typical of Dr. Gumbiner: I got this call one afternoon in the dental office from Dr. Gumbiner's secretary. It was about one o'clock. His secretary said, "Dr. Gumbiner would like to see you right now." I'd never even talked to the guy before. I had a whole afternoon of patients, so I called the secretary back and I said, "Well, I'd love to, but does he really want me to cancel my whole afternoon of patients?" And she said, "Well, that's okay. Get here as soon as you can." So I went to the office, and he sat me down and he pulled out his dictating machine from his drawer and dictated a memo to the current dental director, saying, "You are hereby terminated." Then he said, "We'd like you to be the dental director." I was thinking to myself, "I'm very wet behind the ears. I'm a new dentist. I haven't even managed a practice before." He said, "Well, we're going to do this because dental directors are scarce as hen's teeth. We believe in promoting from within and you're on ninety days' probation. We'll see how you do." [laughter] And he never did get back to me on whether I'd passed probation or not.

Hughes: I think you can presume by now you did.

Pingle: Yes. How he came to the decision to promote me was through Hal Johnson, who had gone through the staff manager program with FHP. One of his first assignments was to act as kind of a management liaison to the dental and optometry departments. Hal met with me a few times and went out to lunch with me and recognized my interest in improving things, making them work better.

Hughes: So doubtless that was how Dr. Gumbiner heard of you.

Pingle: Absolutely.

Hughes: Was Hal Johnson in the president's office at that point?

Pingle: No, he was a manager.

Hughes: Why did Dr. Gumbiner fire the previous dental director?

Pingle: Well, the dental director was doing some things that really were costing the company more than they needed to and wasn't providing good dental care. We are a health maintenance organization and I believed that we should be providing preventive dental services to our patients. We weren't doing that. Another thing was that the former director had the dentists doing all the prophylaxis, the dental cleanings. I said, "That doesn't make too much sense. We can hire a hygienist at a lot lower cost and get the job done." So there were several managerial issues, and there were also some personal issues that came up that caused some problems.

Hughes: Was it typical of Dr. Gumbiner to fire somebody summarily?

Pingle: No. He would talk about summarily firing people at times, but usually rationality prevailed.

Corporate Director of Associated Services, 1978-1979

Hughes: Then four years later you became corporate director of associated provider services.

Pingle: Well, I'd like to back up one step before that. In 1975, FHP's malpractice insurance rose 600 percent overnight. Dr. Gumbiner decided that, "Those darn insurance companies have never paid settlements for us anywhere near the premiums that we have been paying them, and I'll be darned if I'm going to give them six times that amount and they'll just pocket the money." So he

decided that FHP would go self-insured. I thought, "Gosh, that seems like a very risky thing. I don't know if that's a wise thing to do." Well, six months after that he said, "Ray, we need to spread general management responsibilities around, and I'd like you to become responsible for a malpractice prevention program, and make sure that I made a good decision [in initiating the program]." So he charged me as a dentist to set up a medical risk management, risk prevention program, which I did.

Hughes: How did you go about doing that?

Pingle: I just sat down and logically thought it out. I did retain a malpractice consultant who helped us develop our program. I just worked away at it.

Hughes: It turned out to be a good thing?

Pingle: Yes, it did. Dr. Gumbiner did, in retrospect, make a good decision. We've saved millions of dollars having done that. The part I enjoyed about it was, since we were now on the hook for any malpractice liability, it was in our financial interest to provide the highest quality of care, and so it gave us a financial incentive to do the best we could. That was the fun part to me. I could go around and use this big economic club to say, "Well, we better do it right or we'll get a malpractice lawsuit!" [laughter]

Hughes: Did that lead to your appointment as corporate director of associated services?

Pingle: It may have helped, but wasn't the only reason. After I had been dental director for roughly five years, Dr. Gumbiner was pleased with the job I had done and so he wanted me to assume responsibility for a broader range of services. So then I had responsibility for not only dental but also the optometry, pharmacy, health education, mental health, and DHR [department of human resources] departments.

Hughes: Did that position take some self-education?

Pingle: Well, Dr. Gumbiner has always been a great believer in education and served as an excellent role model, plus continually reminded us of the importance of education and encouraged us to take additional education. So I took postgraduate education courses as a dental clinician. I also took a lot of one-, two-, and three-day courses in general management. Dr. Gumbiner also had an audiocassette library of management courses, and I'd listen to tapes when I was driving around.

Dr. Gumbiner likes to teach. He'd sit and talk about general management concepts and so on. And then on my own initiative I learned a lot of those things.

Corporate Vice President of Medical and Provider Services,
1979-1984

Hughes: Your next position was corporate vice president of medical and provider services.

Pingle: Right. I became the first corporate vice president of medical and provider services. It was very unusual to have a dentist be responsible for physicians, especially in an organization run by a physician.

Hughes: How did that work?

Pingle: Well, actually it was interesting, because a year prior, in 1979, Dr. Gumbiner had gone through a series of medical directors that either didn't work out or he didn't think they were up to the job, but was pleased with the work I was doing. Plus, I'd worked with the medical side of things in my malpractice capacity quite a bit. In APS [associated provider services], I worked with the pharmacy department, health education, and so on, which work with physicians.

Dr. Gumbiner asked me if I would like to assume this new position. At that time I felt I wasn't ready, and I'd seen some medical directors come and go, and I thought, "I really don't want to be there." But a year later, I needed some more challenge, because I felt I had accomplished a lot in the APS area and could do the job on the medical side. So I asked him if the offer was still open, and he said, "Well, I'll have to think about it." He did for a few days and came back and said, "It's yours."

One of the first assignments he gave me was a planning conference in Hawaii. We had a medical director for Guam whose name was Dr. Pieter Huietema. Dr. Huietema was a European physician, very distinguished gentleman, excellent surgeon, and at that time was probably about fifty or fifty-five. Now he was going to be reporting to a thirty-two-year-old dentist. Dr. Gumbiner said, "Ray, by the way, I haven't gotten around to giving Pieter his annual review. Would you mind giving him his review?" [laughter] I had worked with Pieter in other capacities and we had gotten along fine. I said, "Well, I'll give it my best."

So I took Dr. Gumbiner's narrative comments and hooked them up with a numerical score based on what I knew about Pieter and what Dr. Gumbiner gave me, and gave Pieter his review. Pieter didn't like the review. I gave him an eighty-seven, I remember, and he was used to getting ninety-eights. He said, "Well, who are you giving me this kind of a review? You're just a young dentist." And I said, "Well, yes, I'm young by comparison with you, and I am a dentist, but Dr. Gumbiner has put me in charge and I really put some work into this. This is the fairest evaluation I can give, and if it's warranted to go higher next time, I'll be happy to do that."

Hughes: He accepted that explanation?

Pingle: Yes. We really developed a lot of mutual respect for each other and in fact five years later, he assumed my position. [laughter]

Hughes: What were you rating in those evaluations?

Pingle: Cost control, staffing, staff morale, utilization management.

Hughes: Was every FHP physician evaluated every year?

Pingle: Yes. Dr. Huietema received his review as a medical director, but all FHP managers, whether they are physicians or otherwise, receive an annual evaluation of their performance, and their pay is based in part on that performance evaluation.

During my tenure as vice president of medical and provider services, I spent about a year and one-half as one of the four key people who designed FHP's first hospital, the one right here in Fountain Valley. One of the things I've always been very grateful to Dr. Gumbiner for is his ability to just identify people that he believes are competent, can get the job done, and lets them do it, no matter whether they're a dentist or young or old. It didn't matter. If you did the job, he'd give you an opportunity. He's allowed a lot of us, at a younger age than other companies allow, to have some very significant responsibility. When you feel that responsibility, you're so afraid you're going to mess it up that you work extra hard and it spurs you to do an excellent job at times.

Hughes: Also, he's a pretty stern taskmaster.

Pingle: Yes, he is. [laughter]

Regional Vice President of IPA Senior Plans, 1984-1986

Hughes: Then you became regional vice president of IPA senior plans in 1984.

Pingle: Right. This was another challenging assignment. Having a dentist managing physicians was fine when we were smaller, and I felt honored that I was allowed to stay in that position for five years. But at some point, clearly, the company had to have a physician in that role. So in late 1984 Dr. Gumbiner decided it was time for a change, and Dr. Huitema assumed that position. Then I thought of becoming a corporate vice president of APS, but that was very similar to the previous job I had had, and I knew I was going to be bored with that.

Dr. Gumbiner had just started the staff model senior plan a year earlier. Now he was going to expand it into an IPA, and this was the first time that FHP was going to engage in an independent practice association-type of health care delivery. I thought, "Gee, that sounds challenging." So I talked to my boss, Dave LeSueur, and said, "I'd be very interested in doing that." He said, "Okay, I'll talk to Dr. Gumbiner about it," and he came back and said, "Fine. It's yours." So I became the first regional vice president of the IPAs for FHP.

Hughes: That again was a whole different system that you had to learn.

Pingle: Yes, I had to basically set up a whole new line of business pretty much on my own. I did have some good functional support from some departments, like marketing, and I had good personnel support. But in terms of enrollment systems, recruiting physicians, setting up payment systems for physicians, financial reporting systems, all those I set up from scratch.

Vice President of Management Information Services, 1986-1987

Hughes: Then you became vice president of MIS. What does "MIS" stand for?

Pingle: MIS stands for management information systems, the computer department. What happened there was, Dr. Gumbiner had an internal auditor, who used to work for the FBI. Dr. Gumbiner sent him on an audit to the MIS department, and he found out that the MIS department was in deep trouble, was way over budget, way behind schedule. Dr. Gumbiner went to a course on what CEOs need to know about running a MIS department. Two key concepts he came away

with were: MIS should report high up in the organization. Don't bury the reporting relationship for MIS in the finance department, because it's strategically important to the success of the organization. Secondly, don't put an MIS technical person in charge; put a general manager in charge that understands the business, someone who can talk with the techies and organize them, but someone who's not a techie himself.

Hughes: To integrate the information where it counts.

Pingle: That's right. I've had a reputation for years at FHP for being analytical, detail-oriented. I was one of the first employees of FHP to get a personal computer at home, and everybody knew that was my hobby. So I think Dr. Gumbiner just thought, "Well, Ray's the perfect guy for this job," so that's what happened.

Hughes: Then you moved to corporate vice president of dental affairs [1987-1988]. What did that entail?

Pingle: Well, when I was running the MIS department, I put together a long-term strategic plan that the company implemented. It took us from doing all of our computer work on a prime computer system to an IBM mainframe computer system. But I think Dr. Gumbiner, Bill Price, and others thought, "Gosh, MIS is such a critical thing to the company. It requires some technical expertise, some people that have had expertise doing this before." Even though I had done a great job to that point, they didn't understand MIS well enough, and believed that we couldn't risk having an MIS problem again, because the company had been burnt three or four times over fifteen years in MIS systems. They thought, "We've got to have somebody whose whole career has been MIS." So they decided, "We need to bring in someone else."

Corporate Vice President of Dental Affairs, 1987-1988, and
Corporate Functional Responsibility for Claims, 1988-1991

Pingle: So then I was given the assignment of VP of dental affairs, and I thought it would be great to just coast for a while. But I got bored to tears--I was only in that position for nine months--and went to my boss, who was Hal Johnson, and said, "I need more challenge. I'd like to get much more involved in systems from the user side. My expertise is I'm a general manager; I know how the company works; I know how MIS works, and I can fulfill a role there." Hal said, "Great. We've also been looking for a VP of claims. Why don't you do both?" So I said okay, so that's how I got my next job [1988-1991]. [laughter]

Corporate Vice President of Health Care Delivery Systems Support,
1988-present

Pingle: Then just within the last three months the claims function has been given to Jana Cescolini, who had been my associate vice president of claims. Now I'm spending full time on coordinating systems. My new title is corporate vice president of health care delivery systems support. So now I'm spending full time working with the health care delivery, functional vice presidents--medical, hospital, operations, APS, and others--to find out what needs they have. Of course I've got a good idea already of what kind of systems they need. I then work with them and MIS to find systems to solve those problems.

FHP's Board of Directors

Hughes: You're also on the board of directors.

Pingle: Not now, but I was. From 1977 to 1983 I was on the board of directors, but I haven't been on for several years now.

Hughes: Could you say something about the composition of the board of directors?

Pingle: Well, Dr. Gumbiner was continually changing the board of directors and the bylaws.

Hughes: Under what pretext?

Pingle: Well, I think he had a couple of objectives. One was that he was sincerely interested in getting outside expertise on the board to help do a better job of running the company. But he wanted to maintain control of the board, and so he would balance those two objectives. For a while the board was divided into thirds: two outside directors, two inside senior managers, and two physicians, since we're a health care organization. Typically, the FHP-elected chief of staff would have a position on the board.

Hughes: Was that in the bylaws?

Pingle: That was in the bylaws in times past, right. It's changed since then.

Hughes: How were the others chosen?

Pingle: Basically through an interview process. Dr. Gumbiner would interview them.

Hughes: Who were the outsiders?

Pingle: Well, Gunther Klaus, who was an outside management consultant, was on the board for years and years. He was also a personal friend of Dr. Gumbiner's, but I think he played a very effective role on the board. For one thing, Dr. Gumbiner didn't intimidate him, and so he wasn't at all shy about expressing his views to Dr. Gumbiner.

Hughes: Was it an active board while you were on it?

Pingle: Yes, it was fairly active.

Matrix Management System

Hughes: Do you want to say anything about the matrix system?

Pingle: Sure. I think when Dr. Gumbiner implemented the matrix system in 1980, he was continually thinking about management structures and how to make the company more effective. One of his philosophies had always been that if you're a growing company, you need to staff your management positions to where you want to be, not where you are now. So you have to be developing management in advance. This means currently you should be overstaffed in management if you want to get to be a larger company.

So he personally investigated matrix management. He gave us all a book to read on matrix management, and he had a matrix consultant come out and talk to us. He kind of dragged us all, kicking and screaming, into matrix management. Some of the advantages he saw were that it would give you a whole other cadre of managers. If you were missing a regional vice president or you were starting up a new region, you could pull up your functional vice presidents and put them in that role.

Another reason is that Dr. Gumbiner has always had some difficulty in having a single individual totally accountable and responsible for a function. He likes input from multiple sources on critical decisions and business activities. So in matrix, you basically have two people looking at every key decision. You've got a regional vice president and a functional vice president. He believed that you would end up with better decisions in a matrix structure.

Thirdly, he thought that with two people you would get better manpower development. For example, I was corporate functional vice president of medical and provider services, and I'd have a regional vice president. We had a regional medical director reporting to both of us. If that medical director was doing a terrible job, maybe one of us was a friend of that person and would protect him, and the other one would say, "Let's get rid of this guy and put somebody else in who's competent." On the other hand, we might have a real rising star, who might threaten me and maybe I'm afraid this guy is going to get my job. And the regional vice president says, "This medical director is great. He ought to have Ray's job." So it provided a mechanism for developing and retaining a more competent staff.

Hughes: Did the system work well?

Pingle: I really think it worked. When we went through the implementation of matrix, we had one person that really couldn't fit into that structure, and we had to work on some rules on how we would work with each other. Once we did that I think it worked quite well for the first three to five years. But as the company continued to grow and become more complex, it became less and less effective.

Hughes: The system doesn't work very well with complexity?

Pingle: That's right.

Hughes: So what is the system now?

Pingle: Well, the roles have been completely changed. One of the key points that Dr. Gumbiner made when he installed matrix in 1980 was that the functional vice presidents would not be just a corporate staff of consultants and auditors, that we were line managers and that we had just as much responsibility for the bottom line as the regional vice presidents. For example, the regional medical director would get his annual review 50 percent based on what the regional vice president thought, and 50 percent based on what the functional vice president thought. We had to coapprove annual budgets, coapprove all capital expenditures, interview and coapprove who got the position for the regional medical director. So it truly was an equal line management responsibility. And de facto in some cases, the corporate functional vice president, because he would tend to have more functional expertise, oftentimes would give more direction in our function than the regional vice president would.

Hughes: Did people like the system?

Pingle: I think most bought into the system. I think they saw some advantages. There were some that didn't like having two bosses. But I think the system worked, because just like the kid with two parents, if you don't get the candy from one parent, you can try the other. Actually, the corporate functionals tended to become champions for their function, to try and get more resources to make their functions work better. So in that respect I think they did like it.

The way it's changed now is, because FHP became so complex, we are consultants and advisors and experts. But we still have some teeth in what we do in that we define performance requirements on how the regions need to function, and then we audit against those. If there are discrepancies, then we call those to the attention of senior management and we work with them on solutions.

Independent Practice Associations

Hughes: What about FHP's movements into New Mexico and Arizona in 1985? Were you involved in any way?

Pingle: Well, initially I was involved to the extent that since California was the first IPA, we had some of the people that were starting those regions come out to California to see how we were doing things. I put on one or two training sessions and would act as a consultant, or my staff would act as consultants, to the people setting up the Arizona and New Mexico regions.

Hughes: That was quite a change for FHP to use the IPA model. It's sort of the antithesis of the staff model.

Pingle: Yes, it sure is. Well, in fact, in 1983, if you'd said "IPA" you would have been shot as a communist, because our culture was entrenched in staff model, staff model, staff model as the only way you could control the quality and cost of health care.

We started off with our staff model senior program in Long Beach in 1983. We were a demonstration contractor, which meant we had the franchise; we were the only one of a few HMOs in our service area that could sell to seniors. Very soon the feds were going to open that franchise and allow anyone that qualified to sell the senior product. So we had a window of opportunity.

Well, there was no way that we could build facilities and hire physicians fast enough to take advantage of that window of

opportunity. So we elected to experiment and start off on a senior plan through the IPA. And it's proven to be very successful. One of the reasons it's been so successful is we applied to the IPA model a lot of the utilization management and marketing and other techniques that have served us so well in the staff model.

Hughes: What is Ultralink?

Pingle: I'm probably not the best person to ask about Ultralink.

Hughes: Who would be?

Pingle: Dr. Jim Austin.

Hughes: Do you want to say anything about recent programs?

Point of Service Product

Pingle: One product that I'd like to comment on is the POS product, point of service product. Members sign up for the POS product and they can decide on a moment-by-moment basis where they receive their care. They have two choices: they can receive their care from our HMO network, which can be staff model, IPA model, or medical group model; or they can go to see any physician or health care provider in the community. Now, they pay a penalty for that, because if they go outside of our network they may pay 20 or 30 percent of the cost, whereas if they receive it through the HMO they only pay a very small copayment.

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Pingle: There is still a significant portion of the commercial health care marketplace out there consisting of people that are still a little leery about joining a managed care organization because they feel it's too constraining. So we feel this product will enable us to have those people come in and test the [HMO] system, and they've got a safety valve. If they don't like it, they can still go to their doctor down the street. But they can try it, and if the care and services meet their requirements, they can save a lot of money.

Hughes: Is it selling?

Pingle: It's administratively a very complex product, and we'll be offering it probably within the next sixty days.

Hughes: Well, we've got about two minutes. What would you like to add?

Pingle: Well, I've had some tremendous opportunities here at FHP. I've been here twenty years. I've been kind of the utility vice president for the company. It's really been terrific for me to be able to work for one company and have several careers, so I've been continuously challenged. As I stated earlier, I've been very appreciative of the opportunities that Dr. Gumbiner has given me to participate so actively in the development of the company, to have a dentist run the medical department, the MIS department, be a general manager, design a hospital. It's been just a phenomenal experience.

Hughes: Well, I think that's a very good place to end.

Pingle: Thank you.

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Berkeley, California

AN INTERVIEW WITH WESTCOTT W. PRICE, III

Interviews Conducted by
Sally Smith Hughes
in 1992



William W. Westcott Price, III, 1991

BIOGRAPHICAL INFORMATION

(Please write clearly. Use black ink.)

Your full name WESTCOTT WILKIN PRICE, III

Date of birth MAY 6, 1939 Birthplace GLENDALE, CALIF.

Father's full name WESTCOTT WILKIN PRICE, JR.

Occupation MECHANICAL CONTRACTOR Birthplace ST. PAUL, MIN.

Mother's full name EDNA JOHNSON LANGE PRICE

Occupation NONE Birthplace NEW JERSEY

Your spouse HILLARY CLARK HANEY PRICE

Your children CHRISTOPHER LANGE PRICE, GRETCHEN
STEVENS PRICE MOODY, WENDY ROBBINS PRICE

Where did you grow up? LA CANADA, CALIFORNIA

Present community ROLLING HILLS, CALIFORNIA

Education B.S. IN BUSINESS AT UNIV. OF COLORADO
& M.B.A. FROM UNIV. OF SO. CALIF.

Occupation(s) PRESIDENT & CEO OF FHP INTERNA-
TIONAL CORP., A HEALTH MAINTENANCE CORP.

Areas of expertise MANAGEMENT, FINANCE AND
GENERAL BUSINESS

Other interests or activities SAILING, TENNIS

Organizations in which you are active ECONOMIC ROUND TABLE,
CHAIRMAN'S FOUNDATION OF THE REPUBLICAN SENATORIAL LEADERSHIP,
BOARD OF ADVISORS FOR UNIV. OF SO. CAL. SCHOOL OF
PUBLIC ADMIN., AND THE SCHOOL OF BUSINESS. BOARD
OF ADVISORS FOR SCHOOL OF HEALTH AT CAL. STATE
UNIV. AT DOMINGUEZ HILLS.

INTERVIEW HISTORY

Of the people interviewed for this oral history series, Mr. Price is the most recent arrival at FHP, and as president, chief executive officer, and vice chairman of the board of FHP holds the most senior positions. He came to FHP in 1981 with degrees in marketing and business administration and experience in the banking, restaurant, and hospital businesses.

Mr. Price was interviewed on February 18, 1992, in FHP's corporate offices in Fountain Valley, California. He tells of his first position at FHP as senior vice president in the office of the president, second only to the company's founder, Robert Gumbiner. Sometime thereafter, Dr. Gumbiner appointed a second vice president, David LeSueur, and created the office of the president as a means to decide who was to follow him as president and chief executive officer. As Mr. Price describes in the oral history, a competition ensued between the two vice presidents. The result, of course, is history.

He also speaks with authority of FHP's transition from nonprofit to for-profit status, a process with which he was intimately involved, and the place of the HMO in the current health care market.

Sally Smith Hughes
Interviewer/Editor

October 1993
Regional Oral History Office
The Bancroft Library
University of California
Berkeley, California

XII AN INTERVIEW WITH WESTCOTT W. PRICE, III**Background**

[Date of Interview: February 18, 1992] ##

Hughes: Mr. Price, tell me please where you were born and educated.

Price: I was born in Glendale, California, in 1939. I went to high school at Harvard School in North Hollywood where I was a boarding student. I would march to class, march to chapel, and march to meals. It was like being sent to jail for five years. From there, I went to the University of Colorado where I spent four years and got a bachelor of science in business. I majored in marketing. After graduating, I went into the navy for two years because I had been in the Naval ROTC [Reserve Officers Training Corps] at the University of Colorado. Those were the days where if you were not in ROTC, you could have been drafted into the army.

I spent two years in Hawaii in the navy. As soon as I was finished with that requirement, I came back to California and went to the University of Southern California where I got my master's degree in business. I majored in finance and management.

Hughes: Where you thinking about the health care industry at that stage?

Price: No. That was not on the top of my agenda. I always pictured myself as the captain of a manufacturing company of some sort, where I was manufacturing millions of widgets and selling them all over the world. That was my vision of what I wanted to do.

Hughes: And it didn't happen.

Price: No, that didn't happen. Interestingly enough, I have never been in the manufacturing business.

While I was getting my degree at the University of Southern California, I was working full time at what was then United California Bank. That is now known as First Interstate Bank. I started off in their management training program. I had interviewed with a number of other companies, including Shell Oil and Aetna Insurance Company, but United California Bank was the only company that would agree to allow me the time and send me to school to get my MBA. So that's why I picked the bank.

Generally, I found banking boring. But I was there for, I think, five years. After I had gotten my master's degree, nothing seemed to change for me in the bank. It didn't seem to make any difference that I had gotten my master's degree, though clearly I was the one responsible for my own career. The opportunities seemed to be so far away that I left the bank and went to work as the assistant to the president of a fast-growing conglomerate, and I made acquisitions for that company. That company was known as Nova Tec at the time. Then I ran some of the companies that I had acquired.

Hughes: That sounds a bit more exciting.

Price: Yes. For my personal makeup, that was far more exciting, more challenging, and opened up a whole breadth of new experiences that I never would have had if I remained at the bank.

Hughes: What happened next?

Price: Then I left that company and I went to work for a company called California Medical Centers which was a publicly held company that operated convalescent hospitals in southern California. It had a chain of pharmacies and some other related medical activities. I had become a shareholder in J. J. Pike Corporation that was acquired by California Medical Centers, but the shareholders of J. J. Pike Corporation took enough stock of California Medical Centers to control California Medical Centers.

So I came in as the chief operating officer. That was my first opportunity to run a publicly held company, which again is something I very much wanted to do. It was a company that was in difficulty, so I had the great opportunity to try and turn around a publicly held company with unhappy shareholders, which we did, and we did it very successfully. It was a grand experience. But in doing so, we had to downsize the company, sell off so many of its assets, that there wasn't much of a company left.

So then I joined a group of three people who were the senior management of Denny's Restaurants, and we found our financing and started a restaurant company. I spent the next nine years with

that company, building up a chain of restaurants in the western United States. It was a company that did fairly well. Along the way, we acquired many of the restaurants that Lowry's Foods did not want. So we brought those restaurants in and built up the company.

The original plan was to take it public. But we just didn't earn enough money to make that worthwhile. We had a big partner, the Bixby Ranch Company, and they got tired of waiting for all the riches they had hoped to generate from this company. They decided maybe the best thing to do would be to sell off each restaurant individually and make money on their investment that way. So that was a disappointment because we had spent nine years putting together a management team, building a concept, getting it known in the markets we were serving.

Joining FHP, 1981

Price: It was at that time that I met Dr. Gumbiner. I knew that the HMO concept made sense, not because it was embraced by the public--in fact, quite the contrary was true then. HMOs were thought of as being a second-class way of delivering health care.

Hughes: When was this?

Price: That was 1981. I joined FHP in June, 1981.

The company was holding down the costs; it was delivering care at a lower cost. So for the segment of the market where that was important, there was a niche, I felt. I believed that if you could do that in any business and run a good company at the same time, you had the opportunity for a much expanded market and the basis upon which to build a company.

The other thing that I saw when I came with FHP was that this company was a not-for-profit company. Working for a not-for-profit company was about the last thing I ever wanted to do. But I understood that there was a chance to turn this company into a for-profit company.

Hughes: That was being talked about in 1981?

Price: No, it was not. But I was aware that it was being talked about elsewhere, not within FHP but in other companies. At that time, there was only one publicly held HMO, and it was only quasi-publicly held. It was U.S. Health Care Systems on the East Coast.

A venture capital company called Warburg-Pinkus--I think it used to be E. M. Warburg, a company I had known for a number of years because of the acquisition activities I had been in before--was a very aggressive venture capital firm. It had made an investment in U.S. Health Care Systems. I knew that Warburg-Pinkus would never make such an investment in a company they couldn't take to the public. So I knew there were some initial stirrings in the marketplace that HMOs could possibly be a public vehicle some day.

Hughes: Did you discuss this idea with Dr. Gumbiner at that point?

Price: At that point, no. I did not know his feelings on that issue. He had been running a not-for-profit company for such a long time, I really didn't know whether he thought that was a good idea or not. It wasn't germane to my initial discussions with him. Nevertheless, at the same time, I knew that Maxicare was in the process of converting from a 501(c)3 nonprofit corporation to a for-profit corporation. I did a little research to find out that there were a series of laws in place in California which permitted that.

I looked at FHP as a company that had been around for, at that time, about twenty years. I think the company was doing approximately \$50 million in annual revenues. I saw a company that was holding down costs. That was the philosophy of the company as I understood it at the time, and that here might be a very attractive vehicle to convert to a for-profit company, take public, raise the equity capital that would be needed to expand it. Since it was doing a good job in a basic business, there might be the makings of a very large company here. That's what attracted me, because I did have some background in the health care business.

Hughes: Because of your experience with California Medical Centers.

Price: Yes, that's right. So that was my motivation.

Hughes: But without even discussing it with Dr. Gumbiner? He was a very potent force. I would think you would have had doubts about whether conversion to for-profit was even a possibility.

Price: No. I might have been naive at the time, but no I didn't. This was a capital-intensive business. If you look around FHP, we are known for our medical centers. We had no hospitals at the time, but we had medical centers. Those take a lot of money. Also, the research that I did before I joined FHP said that the HMO concept was beginning to stir. Kaiser Permanente was by far, and still is, the largest HMO. What are known as IPAs today really were not thought of as being HMOs as much as the staff model, Group Health

of Puget Sound, Harvard Community Health, and HIP [Health Insurance Plan] of New York. Those are staff models, that is, they have their own medical centers. When you thought of an HMO, that's what you thought of, just ten years ago. The idea of contracting with doctors and hospitals in the IPA format was not really thought of as being an HMO at the time.

Hughes: Of course, FHP had used the IPA on Guam in the seventies.

Price: Yes, but to such a small extent it really didn't represent a demonstration that would work elsewhere. Guam was a very unique market.

Hughes: And that's probably the way people looked at it. Fine for Guam, but what does it have to do with us?

Price: That's right. That's the way I initially viewed it.

In any event, there was no way that a company like FHP as a nonprofit company was going to be able to raise the capital necessary to become much more than it was unless it could tap into the equity markets. That was my whole background. It only made sense that this company would have to go public.

Hughes: Was that expertise what Dr. Gumbiner was seeing in you?

Price: I have no idea what he saw in me. I know that the company needed management at the time. When I came in, I did not understand the business. I had a broad, general background in business but it was not directed at an HMO, so I think Dr. Gumbiner was probably taking a chance on me. He didn't know who I was.

Hughes: And you were too experienced to put into one of the management training programs. [laughter]

Price: Yes. That's not something I would have wanted to do. But I did know that I needed to understand this business as quickly as possible. But I did understand the basics. I knew enough at the time to understand that here was a company that had the opportunity to expand and be a large company, if certain things were done. The barriers to getting those done, as far as I could tell, were not there. I thought, well, it's worth a try. Maybe I can contribute something. Maybe I can help bring this about.

So that's what I did. At the same time, I had an opportunity to go in as the chief operating officer of a restaurant company, and I had some other opportunity which I don't remember. But I chose FHP because I felt that the market was so large that there was an opportunity that seemed to be developing in the country. I

think in retrospect I made the right decision. It has been a company that I feel I have contributed to and enjoy. I have enjoyed building this company and participating in a concept that today is right on the forefront of the discussions involving national health care in this country.

However it may turn out, we are doing a very good job. The quality of the health care we are delivering is excellent. We are able to deliver it at a lower cost. What else is there?

HMOs in Today's Health Care Environment

Hughes: Is the government paying attention?

Price: Absolutely. This is a model of a solution to the health care problems in this country.

Hughes: You're meaning the HMO concept in general.

Price: The HMO concept. It's referred to today as managed care, coordinated care, and there are various gradations of what that is. But by far, the best of those is the traditional HMO, because it has the best opportunity to control the access, the quality, and the costs.

Hughes: And by traditional you mean the staff model? Or are you including all forms?

Price: No, the staff model, where you have your own facilities and where the medical staff are full-time employees of the company, and you have control over equipment and utilization. This gives you the best opportunity to manage what you are doing. When you can manage what you are doing, you have the best chance to control your costs.

Hughes: Yet FHP is increasingly using IPAs.

Price: Yes. Today, IPAs represent a way to expand much faster than in a staff model. The reason is obvious. In an IPA you don't need to build buildings. You contract with existing physicians and hospitals. You deliver your health care through those people you have contracted with. Though that is an attractive way to expand today, and some of the companies who are expanding the fastest right now are doing it through the IPA mechanism, there are some unknowns down the road with respect to IPAs.

You have to go back to the basics. The basics are that you may contract with an outside doctor or hospital, but you do not have the degree of control over how they practice, what they do, or the quality they deliver, as you do in a staff model where you have your own facilities. I see on the horizon some things that may one day, perhaps not too far away, reverse this again, where the IPAs may become a difficult way to deliver health care and the staff models are thought of as being the preferred way.

There are a whole range of things that cause me to say that. A couple of them may be interesting. First, in the last ten years or so, there have not been many new hospitals built. There seems to be a polarization where the small community hospitals are falling away. They are being closed down or sold off. The better-known hospitals are becoming more prosperous, growing and capturing a larger percentage of the market. Well, as that happens and more of these hospitals fill up, they are going to be less inclined to contract with managed-care companies. They don't need to.

Initially, the hospitals that used managed-care companies and where you could make your best arrangements were the ones who needed your members to fill up their beds. If their beds were filled, they would not have talked to us at all. The over-sixty-five population is the fastest growing segment of the U.S. population. If you are over sixty-five, on average, you use almost four times the amount of care that a person under sixty-five does.

You can see two things going on simultaneously: there are fewer hospital beds made available, but the need for beds is increasing because of the aging population in this country. So what does that mean? It means that the hospitals are going to fill up. When they fill up, they are not going to be very interested in cutting favorable deals with managed-care companies, or as favorable.

Another thing going on in the marketplace is that the stereotypical physician who has his or her own office with a nurse and a nice waiting room and so on is beginning to disappear. What's happening now is that fee-for-service physicians are banding together into groups. As groups, they are becoming more sophisticated. They are looking to managed-care companies as their primary or sole source of business, not the individual who walks in the office as a fee-for-service patient. As these groups get together and cast around for how it is they are going to get their business, they look to managed-care companies. They are becoming more skilled in how they deal and contract with managed-care companies. They are beginning to figure out how to

get a bigger piece of the pie. The managed-care companies, the HMOs, the IPAs, are not going to be able, in my view, down the road, to cut deals that are as good as they have.

I see the margins for the IPA portion of the business down the road may start to erode. I view the IPA phenomenon today as an interim delivery mechanism over the longer term. Again, you've got to get right back down to the basics. In the staff models, you are able to control what you do. Now, it's a lot of work and it takes a lot of management and attention, but at some point, I just don't believe that the IPAs are going to be the great opportunity that they seem to be today.

My focus has been and is today figuring out how to deliver health care in the staff model operations more efficiently. We could apply some of those same concepts to the IPAs, but our future is figuring out, being innovative, being on the cutting edge of how to deliver health care at a lower cost without degrading the quality as we define quality in this company. That's where I believe our long-term benefit is.

Senior Vice President of FHP, 1981-1991

Hughes: Let's go back to your arrival at the company in 1981. You came in as senior vice president.

Price: That's right. I was the second person to the founder, Dr. Gumbiner.

Hughes: And then some time thereafter, there was a second senior vice president.

Price: Well, before that, Dr. Gumbiner brought in one of our outside directors, Bob Licht, as a senior vice president. So then there were two senior vice presidents, Bob Licht and me. My view was that Bob Licht was not a very good manager and caused far more problems than he solved. I think within a year or so he left.

Then Dr. Gumbiner promoted David LeSueur, who had been running the Utah region and who had started out with FHP in the management development program. David LeSueur was promoted to senior vice president. I don't remember the exact sequence but either simultaneous to that or shortly thereafter, the office of the president was formed, and David LeSueur and I were in that office. David moved from Utah to southern California.

Hughes: The office of the president was always directed to providing the management that would survive Dr. Gumbiner's retirement?

Price: I believe that Dr. Gumbiner knew that at some point he wanted to retire. He had to bring the management up behind him and select that person or persons who would eventually take his role as president and chief executive officer. That's a proper thing to do.

Hughes: Were the people who were in the office of the president being tested, to put it rather crudely?

Price: Yes. I frankly think, in retrospect, that was not a very good idea, because you had two people who were pitted against one another. It was intended by Dr. Gumbiner that one would survive and one would not. It is more than just what kind of a leader or manager you are; it's what kind of emotional makeup you have. What kind of desire for the agony and the additional responsibilities do you have? Do you want the job? I think the worst thing to do is to give somebody a job that they don't want.

So he pitted the two of us together. It was a short period of time in FHP's history that I felt were dark days, because it was not a constructive, positive approach to management. Eventually that just self-destructed.

Hughes: How?

Price: David LeSueur decided that he wanted to go on and do his own thing. By that time we had gone public. We had converted the company to a for-profit business. We had raised equity money which we needed to facilitate our expansion. David LeSueur had some stock and money in his pocket and for whatever reason--I may never know for sure--he decided to move to Arizona and go into the real estate development business. To his mind, that was apparently more attractive than what he was doing here.

So it was at that point that I was made the president of the company. I have since had the opportunity to do the same thing for those people underneath me: put two in the same job and let them duke it out. But because of my experience and the readings that I have done on how that has worked before, I have decided not to do that and I don't think that's a thing I would ever do in the future.

Hughes: How long did that go on with the two of you?

Price: I think it was a year or so. I think the company lost ground, frankly, during that period of time.

Hughes: What were the senior vice presidents responsible for? I know that's an immense question.

Price: I can't recite exactly what each person was responsible for, but in general the idea was that from the corporate office the senior vice presidents would be responsible for the various regions and for the many functional activities in each region.

Hughes: Each of you had both those responsibilities?

Price: No, we had people reporting to us who did that.

Hughes: Were the regional and functional activities separate?

Price: I think one of us had the regions, or some of the regions, and one of us had the functions, or some of the functions. Then as the company began to grow, it was clear that two people couldn't do that and we started to bring in additional managers.

President of FHP, 1991-present

Price: When I became president we formed an executive management committee. I was chairman of that committee and reporting to me were several people who we promoted to the position of senior vice president. They in turn then had the regions and the functional people reporting to them.

Hughes: So it was just a bigger operation.

Price: Yes. That was necessary because the span of control was getting to be such that we had to promote additional people to handle the responsibilities. Running a company that is both a staff model and an IPA, that is, a company that will insure people for health and accident insurance and then turn around and deliver the care, makes for a highly complex business with literally hundreds and hundreds of variables, any one of which could cause serious problems if it were not handled properly.

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Hughes: I can see the challenges.

Price: It is one of the most complex businesses I've ever known or been exposed to.

Hughes: Well, you didn't want it to be boring.

Price: No. That's right. [laughter]

Hughes: How much was Dr. Gumbiner participating?

Price: He was intentionally pulling away more and more in order to facilitate his own objectives, but also so he could stand back and see how the people he had underneath him were acting, how they were managing, what kind of a job were they doing. I admire Dr. Gumbiner a great deal. One of the reasons is his very unusual attitude about succession. I read all the time about founders or former chief executive officers who have "retired," but they never do retire. They lurk in the weeds and try to continue their original role as chief executive officer, believing that they know better than anybody and that no one could do it nearly as well as they did.

I think it is far more common for that to occur than what Dr. Gumbiner has done. He has been able to step back, take a look at the organization, design a mechanism for succession, and then actually carry it out. I know that has been very difficult for him because he is the founder of the company. I do things in ways that he doesn't entirely agree with, yet he has the sense and the fortitude to stand back and to let that occur. Very unusual. Very few executives in my experience, both direct experience and through reading--and I'm an avid studier of business; it excites me, everything about it excites me--have been able to do that. He is very unusual in that respect.

I know he is probably gritting his teeth at some of the things that he sees. He is carrying out his role, I think, exceptionally well. He is chairman of the board. He will make suggestions and he will make his observations. But he has been able to pull away and let the organization function without his day-to-day participation in the operation.

When you look back on his career, that is one of the great things that he has done. Because otherwise, I don't think the company would have the same opportunity to continue to grow and expand. The market changes, perceptions change, things change, and the company has to change with it or it will fail. I think he recognizes that. So that is very, very much to his credit.

Matrix Management System, 1981

Hughes: In the very year that you joined FHP, the matrix system was introduced.

Price: Yes, that's right. I think that again, when you look back on Dr. Gumbiner's career, it was exactly the right thing to do at the time, no question about it.

Hughes: Why do you say that?

Price: Because at the time, the company did not have a lot of management depth. It was not positioned to grow. He took the attitude that if we wanted to be a bigger company, we were never going to get there unless we had the people to bring it about. If you are always behind the times in that respect, you'll never get to where you want to go.

The matrix at that time did a couple of things. It was a mechanism to build management staff for future growth without just warehousing a bunch of people twiddling their thumbs with nothing to do. You would never be able to bring anybody in who was worth anything under those conditions. So it created real jobs for professionals and promoted managers so that there was an opportunity to build the depth of management that we needed. That was critical. When I came with the company, we didn't have any management depth. It wasn't running as any company I had ever seen before, but I think Dr. Gumbiner recognized that if we were going to get beyond that, we had to bring the management in. So this was a mechanism for doing that.

The other thing that the matrix did was to allow a framework for what we called functionals. Really, they are the people who have the technical ability in medical, operations, finance, facilities, and on and on, to back up the general managers who are running the regions and who didn't have all of those specific skills. In other words, we had a general manager who was running the region and was responsible for everything in that region. At corporate, the idea under the matrix was to build a staff of managers who had the specific knowledge in each of these functional areas to complement the vice presidents running each region as general managers.

So now you had two people looking at the same job, the generalist and the specialist. Each was equally responsible for the same area. For example, the vice president of medical affairs in corporate was responsible for the medical activities in all regions. The general manager running the region was responsible for that as well, but also all of the other functions in his region.

That was important because when we started to expand into other geographic areas, just sticking a general manager out there and telling him to build up a new region or a new area would have

been foolish without the support needed from the specialists in corporate. So it was a mechanism to facilitate growth in that respect and in respect to the depth of management. At the time, it was exactly the right thing to do. And it worked very well.

Hughes: From the start?

Price: Yes. Those people who couldn't work within that framework eventually left the company because you couldn't be unidimensional under that kind of a system. You had to be flexible, you had to deal with ambiguity, and you also had to deal with discord effectively, because that system was not for the faint of heart. It washed out what I would consider poor managers, people frankly I didn't want to have around me. In all those respects, matrix was terrific.

Hughes: So you liked it from the start.

Price: You bet.

Hughes: Were you familiar with other companies that had used the matrix system?

Price: Not directly. I had read about it. But I could see how, particularly in the restaurant business where I had been before, that might have worked pretty well. There are a lot of similarities between running a chain of restaurants and this business. All that aside, it just made sense. In this context, it made sense.

Hughes: How was the company running when you arrived, before the matrix system was in place?

Price: When I came, we had operations in Guam. Guam was not growing because there wasn't much population growth there. It was pretty flat. We had operations in southern California--Long Beach and a part of Orange County. And we had operations in Utah. That was FHP. Many of the system's approaches to doing business were not really in place yet. There wasn't much in the way of management depth. Dr. Gumbiner was trying to do everything himself. He was farsighted enough to understand that if the business was going to go anywhere, he couldn't keep doing that. No person could keep doing that. He wouldn't have had enough time to stand back and take a look at what was going on. I think that was probably one of the reasons why he brought in somebody like me to begin to give him the relief that he needed so that he could stand back and take a broader view of the business.

- Hughes: He had put the management training program in place in 1970, eleven years before this time. It must not have been providing managers.
- Price: It did provide managers. It was an evolutionary thing. David LeSueur came out of that program. When I arrived, the California region's general manager was Hal Johnson. He had come right out of graduate school into the management development program. Our current COO [chief operations officer] and executive vice president, Jack Massimino, started with FHP in the management development program. There were people who washed out of that program, but that's what it's for, to try to identify people who are worth their salt. Some really good talent came out of that initial program.
- Hughes: But it wasn't enough; you said that there wasn't depth in management.
- Price: There wasn't. I saw I'm sure what Dr. Gumbiner was seeing and that was, we needed more skilled management. When I came there was no corporate office. There were no functionals in place, with one exception: I think Ray Pingle, who started with FHP as a dentist and had been with the company for some time, was in charge of medical. We had an operations functional, Dolores Kellett, who unfortunately has since died. She began working as a nurse for Dr. Gumbiner when he first started the company as a practicing medicine. We didn't have a vice president of finance. That matrix relationship, the functionals, was just being put together.

So we had a training program in the past and it produced some good people, but for the size of the company when I came, it just didn't have enough management. We had to put the resources behind that.

Transition from Nonprofit to For-Profit Status, 1986

- Hughes: I would like to hear what you have to say about the conversion from nonprofit to for-profit, since that is a particular interest of yours. There were troubles involved with the conversion as you well know. Can you tell me about that?
- Price: There are usually troubles whenever you try to do something that is out of the ordinary. Under the laws of the state of California, when you convert an HMO from a nonprofit to a for-profit, you must have the approval of the California Department of Corporations. That was the case at the time and that is the case

today. The Department of Corporations oversees the process, and one of the elements of that process is to determine the fair market value of the company, because that fair-market value must be contributed by the company to a like charity.

[tape interruption]

The difficulties came over establishing what the fair market value was. During that process, Maxicare, with what I believe was an intent to interfere or interrupt this process so that we did not convert, came in and made an offer to buy FHP. Well, that was in my mind kind of silly because we had, as management of the company, no obligation to convert. If we thought that someone else was going to get their hands on FHP, we just wouldn't convert.

Maxicare tried to interfere with the process. They came in with a bid that was higher than what the Department of Corporations at the time had concluded was the fair market value. They got the state attorney general into the act. The attorney general got into a dispute with the Department of Corporations over who had jurisdiction over HMOs and the conversion of HMOs, and we wound up being embroiled in this lawsuit and went to court. The court was required to make a determination as to who had jurisdiction over the conversion process. This strung on and eventually the court decided that the attorney general had no standing. The conversion was permitted to go forward, and it was completed.

There was a lot more to all of that than I just told you. I could go into all kinds of detail but that in essence was it. We were successful and we converted. That was the right thing for the company to do and the company has grown substantially since then by virtue of its ability to go to the marketplace and raise equity dollars.

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AN INTERVIEW WITH HENRY SCHULTZ

Interviews Conducted by
Sally Smith Hughes
in 1992



Henry Schultz, J.D., 1993

BIOGRAPHICAL INFORMATION

(Please write clearly. Use black ink.)

Your full name HENRY SCHULTZ
Date of birth FEB 25 1915 Birthplace Jersey City N. Jersey

Father's full name SAMUEL SCHULTZ
Occupation INSURANCE CO. EXECUTIVE Birthplace RUSSIA

Mother's full name ROSE ISRAEL
Occupation HOUSE WIFE Birthplace RUSSIA

Your spouse ESTELLE LIEBOW SCHULTZ
Occupation EDUCATOR Birthplace NEW YORK CITY N.Y.

Your children ROBERTA BENOR DAUGHTER, DIRECTOR OF RESIDENCES
STEPHEN SCHULTZ, SON, PROFESSOR OF MUSIC, JERSEY CITY N. JERSEY
NEW YORK, N.Y.

Where did you grow up? JERSEY CITY, NEW JERSEY

Present community LONG BEACH, CALIFORNIA

Education B.A., DOCTOR OF JURISPRUDENCE, J.D.

Occupation(s) HEALTH ATTORNEY

Areas of expertise DIRECTOR OF HEALTH COMPANIES

Other interests or activities MUSIC, INTERNATIONAL TRAVEL

Organizations in which you are active HEALTH LAWYERS ASSOCIATION
GROUP HEALTH ASSOCIATION

INTERVIEW HISTORY

Henry Schultz is a health lawyer whose undergraduate and graduate education was at New York University. After practicing law in New York, he came to California with his young family in 1953 and became a union lawyer. In 1967, at Dr. Gumbiner's request, he joined the fledgling organization soon to be known as FHP where he assumed responsibilities in law and public relations. He later was president briefly of Health Maintenance Life Insurance Company, an FHP subsidiary.

Mr. Schultz graciously came to the FHP corporate offices to be interviewed on February 17, 1992. Affable and loquacious, he readily expanded on the interviewer's questions. Of particular interest is his account of FHP's first Medi-Cal contract for which he repeatedly lobbied in Sacramento. He also describes passage of the HMO Act in 1973, for which he and Dr. Gumbiner testified in Congress.

Mr. Schultz left full-time employment at FHP in 1979 but served as a consultant to the company in the early 1980s. In this capacity, he made many trips around the country for Dr. Gumbiner and arranged a speaking tour in Europe on HMO systems.

Sally Smith Hughes
Interviewer/Editor

October 1993
Regional Oral History Office
The Bancroft Library
University of California
Berkeley, California

XIII AN INTERVIEW WITH HENRY SCHULTZ**Background**

[Date of Interview: February 17, 1991] ##

Hughes: Why don't you start by telling me where you were born and how you were educated?

Schultz: I was born in Jersey City, New Jersey, just across the river from New York City. I had traditional schooling, and attended New York University. I studied pre-law as an undergraduate and then went to New York University Law School. Therefore, I spent seven years in the Washington Square section of New York City where the university is. I graduated and practiced law in New York for many years.

I had the opportunity to come out here to California in 1953 with my wife and two young children. But that position didn't work out, so I had to start something fresh, something new. So I became a lawyer for some unions, working in the legal department. In 1967, I met Dr. Gumbiner in Long Beach, who had organized FHP, Family Health Program, a few years earlier. We met at a coffee shop not too far from here and he described what he had in mind for FHP. He knew of my abilities and my influence in Long Beach political circles.

Hughes: How did he know that?

Schultz: I assume by my reputation in the city.

Hughes: Had you been doing work that was related to the health care industry?

Joining FHP, 1967

Schultz: Yes, I represented the Long Beach City employees in their contracting for benefits--health, vacation, and sick leave. So I became known as the spokesman for the Long Beach City Employees' Association. In 1967 when I was their attorney, Dr. Gumbiner approached me to join FHP. Then it was just a shadow of what it has become today. I forget the details of what I was going to specifically be doing. It was a combination of attorney and handling the public relations and marketing and a few other things. There was no one at FHP then except four or five people. That location was at Spring Street and Palo Verde Avenue in Long Beach. As the years went by, FHP became increasingly more successful. So I played many roles in those years.

When Dr. Gumbiner conceived the idea of FHP becoming involved in prepaid health care, it was very difficult because of opposition by the medical societies and traditional fee-for-service medicine. There were strong opponents throughout the country. How he felt personally I don't know, but there were some indications he was persona non grata, but that's the way it is with the "Establishment," which opposes any concept which is novel.

FHP's Medi-Cal Program

Schultz: I think there are a few key factors which moved FHP into prominence and success. The first was in 1969 when the state of California adopted the prepaid Medi-Cal program, an experimental program, to serve the health needs of the welfare population under Title XIX of the Public Health Service Act. Title XVIII is Medicare. Title XIX is Medi-Cal. FHP applied to the Department of Health Care Services in Sacramento for a Medi-Cal contract. The state agreed to test delivery service on prepaid basis capitations for three welfare categories: OAS [Old Age Survivors], AFDC [Aid to Families with Dependent Children], and ATD [Aid to the Totally Disabled].

Hughes: Did it take a lot of work to convince the state to award the contract to FHP?

Schultz: Yes. A lot of political work was involved and many trips to Sacramento.

Hughes: Was the opposition from organized medicine?

Schultz: Yes. There were several antagonistic hearings. But a one-year contract was granted to FHP. I forget the terms, but what made them better was the report by the state legislative analyst, Alan Post, a very respected economist. He reported that FHP for a period of one year had saved the state 17 percent that it otherwise would have spent for a fee-for-service program for those welfare categories. That report clinched it; this was an impartial legislative analyst not known to be a Santa Claus with public funds.

Hughes: Was that 17 percent mainly hospital savings?

Schultz: I cannot break it down, but I remember the saving was 17 percent.

Hughes: How were you personally involved?

Schultz: Well, I would lobby with the proper people in Sacramento, running back and forth better than twenty times in those years.

Hughes: You had long-term associations with people in Sacramento?

Schultz: Yes, as long as they can be. In Sacramento, they come and go. What does long-term mean in politics? [laughter] Now with the term limitation coming up for consideration, there will be shorter terms, I am sure. So the Medi-Cal contract was the first step for FHP, I believe.

FHP began to gain a solid base of success. It was still a little tentative in nature because opposition was all over the place. But this was a solid contract which succeeded. It had to do with the enrolling of members and how you enroll welfare people. We had to go to welfare meetings, had to hire qualified people who would go out and sign people up. It was very difficult. Each signature had to be verified. Years later, there were about twenty contracts, and some of them were poorly administered. That situation was not particularly related to the Medi-Cal program, but we'll come to that. Life is not all, as they say, peaches and cream.

We were enrolling commercial people, companies, industries, school districts, political subdivisions, et cetera. However, I was not in the marketing end per se. We were able to afford a marketing director and a marketing team. I was doing then the legalities, putting out fires. We'd just started and there were fires to put out in a program not universally loved by the medical profession.

Hughes: Can you give me examples of the sorts of fires that you were putting out?

Schultz: Mostly false rumors that we practiced poor medicine, that our doctors came from poor schools. I went to medical association meetings to defend us. But you can't fight prejudice, you can't fight ignorance, you can't fight jealousy.

Passage of the HMO Act, 1973

Schultz: I think the second development that years later helped FHP move to the point where it now is was the passage in 1973 of the HMO Act. It was signed by President Nixon on December 31, 1972. Dr. Gumbiner and I testified on that bill in Congress. The first bill was defeated. Congress didn't pass it in committee because the AMA [American Medical Association] wanted certain things in it that it didn't get. It took about a year for the AMA to get what it wanted, and then the second bill passed.

Hughes: Can you tell me what the AMA wanted?

Schultz: Yes. The original bill set up two types of HMO models. One was called the staff model, where doctors worked directly as employees for the HMO entity, just like the secretary, just like the cafeteria worker, et cetera, with all employee benefits. The other model recognized in the bill was the group model. FHP is a staff model; doctors work as employees. Kaiser is a good example of a group model where the Kaiser Health Plan and Hospitals hires the doctors as a group. In other words, the doctors' organization is separate. All members of the board of directors of the Permanente Medical Group must be doctors, whereas in the staff model, like FHP, they can be lay people, too.

There are other differences, but staff and group are the two basic models. FHP pays the doctors directly. Kaiser pays the medical groups one total check which is distributed by the doctors themselves, based upon performance, production, or success.

What the AMA wanted and couldn't get the first time was the IPA model, which now is the predominant form of HMO in the country. We have about 520 HMOs in America now. Some are small, some are large, most are medium. The majority are IPA. Of course, the fee-for-service doctors wanted the IPA model, because that was the best of all worlds for them. The doctor could contract with an HMO and service the HMO patients, let's say, in the afternoon, and give his time to private patients in the morning. The doctor who works for FHP as a staff model cannot see private patients.

Hughes: Why weren't IPAs included in the first bill?

Schultz: I don't know. Certainly the AMA had enough clout and lobbying ability to get that in, but maybe it was just overlooked. But that was the reason the AMA exerted influence to kill the bill. Next year it came around and IPAs were included with the original bill. It's a small bill, twenty pages.

Hughes: Is that all?

Schultz: Yes. The regulations weigh about fifty pounds. The bill passed in '72, December 31, but no regs were final until 1974, maybe early '75.

Hughes: Why did it take so long?

Schultz: Well, to write regulations for new acts is very difficult. There are hearings on regulations, thirty days for this, sixty days for that. I wasn't at those hearings. The AMA had its own inputs into the final regulations.

Hughes: Tell me a little about the testimony that you and Dr. Gumbiner gave.

Schultz: Testimony was given primarily by Dr. Gumbiner. I was the attorney-assistant. He testified as to the efficacy and value of prepaid medicine, in which he was an expert. It turned out that what he said was right. There were no stormy hearings. As it turned out now, it's really quite unbelievable. After such opposition, now about 70-72 percent of fee-for-service doctors in America have some affiliation with an HMO, either as an outside provider, participating physician, or as a consultant.

Hughes: But it was not easy to get the HMO concept established in those days.

Schultz: No. Go and visit Australia now. It's America's experience all over again. Australia is usually twenty years behind us and they're just going through this now.

Hughes: Organized medicine is up in arms?

Schultz: Yes. Opposition to HMOs is breaking down now with economic conditions. It'll take another two to three years.

The third thing that FHP had, which I'm not that familiar with because I left in '79 and this development did not occur until some years after that, was the adoption of the Senior Plan, or Medicare, where medicine could be administered on a prepaid

basis to the Medicare recipients. I understand FHP has a very large membership in Medicare and it really was the final shot for its success, in my opinion. I haven't been there since 79, so I cannot speak with authority on that, except for what I know from the industry.

Enrolling Members

- Hughes: The indigent and the elderly have historically been neglected by American medicine.
- Schultz: It was a scandal.
- Hughes: Why did FHP decide to move into those areas?
- Schultz: I believe Dr. Gumbiner had a real feeling to help these groups have medical care that was accessible.
- Hughes: Did he?
- Schultz: I really believe that. He's [also] a good and practical businessman. And with enough patient volume, it would be good for FHP. No one is a complete philanthropist in business relationships. I think it was a marriage of the new enabling legislation occurring simultaneously with his desire to help the indigent and the aged.
- Hughes: Did you ever have doubts that either the Medicare or the Medi-Cal program would succeed?
- Schultz: Yes. I thought it would be very difficult customers to succeed with Medi-Cal in 1967. It was a pilot project with no guidelines about whom and how we enroll, what limitations should there be, what medical exclusions would there be. It was very difficult.
- Hughes: Did you express your doubts to Dr. Gumbiner?
- Schultz: I don't recall it that way. I was on the team, and a team player doesn't do that. No, I just kept on hammering away at it. Expressing my doubts would serve no good. I went myself to the poor neighborhoods and had coffee klatches, so to speak, to tell the people what the Medi-Cal program was and have them sign up, instructing our enrollers how to do it. We were very careful whom we used as enrollers, because that's where the scandals later came in for other groups. Allegedly there were gross

violations in marketing by some health plans in order to secure a person's enrollment.

Hughes: How did FHP go about enrollment?

Schultz: Well, as I said, we were very careful about whom we selected to be enrollers. We trained our enrollment directors very carefully. We never had complaints of that nature. We had discussions with the state about proper enrollment procedures.

Hughes: There was an accusation that FHP was not enrolling sick people.

Schultz: I understand there was an accusation which was never established.

Hughes: Were you involved?

Schultz: No, that was strictly a marketing function, and I don't know if any innuendo allegations were true.

Federal Charges of Diversion of Funds, 1976

Hughes: Before you left FHP in 1979, there was a charge in 1976 that FHP had diverted Medi-Cal funds to profit-making companies affiliated with FHP.¹

Schultz: There was such a charge. The local paper came out with such a headline. I believe FHP was justified in its position. We were subject to many investigations and routine audits from the federal government, because we had a contract for federal employees. So we often had investigators, auditors, examiners, et cetera--that's their job. At times, we were flooded by auditors. I think as a result of our reluctance to agree to additional and redundant audits, some friction and misunderstanding developed.

Dr. Gumbiner and I went to the paper to see the city editor of a local paper, whom I had known over the years. You see, in 1974 I ran for city council. I came in second. My name became pretty well known. I represented 4,000 Long Beach City employees

¹"State health care fraud charged," The Blade-Tribune (North San Diego County), December 12, 1976; "State health plans face Senate probe," Los Angeles Herald Examiner, December 13, 1976; "Medi-Cal left open to abuse," Los Angeles Times, December 13, 1976; "L.B. [Long Beach] doctor denies allegations," Independent Press Telegram, December 15, 1976.

at that time. I lost the election. This editor said he'd just print what the news is.

Hughes: There was a Senate investigation in 1976 headed by Senator Sam Nunn about this issue. Do you remember that?

Schultz: Yes. It resulted in loss of the Medi-Cal contract. We worked hard for about two years to get it back. I remember working hard from 1976 on. And we got it back. I left FHP in 79.

Hughes: Was the period before the contract was restored difficult financially for FHP?

Schultz: I can't speak to that. The finances were not my thing. But let's say it wasn't as it was before. However, our commercial enrollment was getting better because of our good service and accessible centers. So FHP was growing with the general public, industry, political subdivisions, cities, and counties. Yes, there was growing enrollment. I don't know what the enrollment figures were; they can be verified. You mentioned Senator Nunn? He was the chairman of the committee [Senate Permanent Subcommittee on Investigations]?

Hughes: Yes.

Schultz: I was not in Washington at that time. I think Dr. Gumbiner was there with our financial director. There were four or five prepaid health programs at the hearing.¹ I never saw a report of the committee findings. I do know this, that nothing of a punitive nature was done.

Hughes: It was in 1976.

Schultz: The same year as the charge of converting funds?

Hughes: Yes, exactly. I think one incident flowed from the other.

¹For details, see the newspaper articles cited above.

State Attorney General's Office Suit, 1977 ##

- Hughes: In 1977, the state attorney general's office filed a \$1.7 million civil suit against ten FHP directors.¹ Do you remember that?
- Schultz: Yes. That case was handled by a law firm in Century City whose name I forget. But I don't think it ever resulted in a judgment.
- Hughes: I didn't read that it did. Again, it involved supposed diversion of federal and state funds into profit-making organizations.
- Schultz: Yes. I can say that the guidelines then were not clear. I do know with 99 percent of certainty that there were no adverse findings or judgments.
- Hughes: I saw in some of the papers that FHP was thinking about filing a restraining order against the state to prevent discontinuance of care for Medi-Cal recipients.² Did it?
- Schultz: I don't know.³ The lawyers in Century City, I think, handled that. I was a staff man, and didn't always know what was being done at a higher level.

FHP on Guam, 1973

- Hughes: Tell me how FHP came to be involved in Guam, beginning in 1973.
- Schultz: I've been there six times; I should know. To my knowledge, Dr. Gumbiner went to Guam with an associate to take advantage of the great snorkeling and scuba diving? He was very interested in that in those days. And there's no better place for that sport. I think his friend was interested in the hospital. There was no

¹"Long Beach-based prepaid health company faces millions in fines," The Sacramento Bee, February 19, 1977; "\$1.7-million Medi-Cal suit hits L.B. firm," Independent Press-Telegram, February 19, 1977; "Health plan directors sued," Los Angeles Herald Examiner, February 20, 1977.

²"16,000 patients lose Medi-Cal care," Independent Press-Telegram, February 27, 1977.

³FHP and the state attorney general's office reached an out-of-court settlement. See Independent Press-Telegram, April 20, 1977.

real plan, as I judge it, to set up a prepaid program at that time. But Dr. Gumbiner is an innovative man, and probably discovered a business opportunity. A day or two after he came back he called some of the executives to a meeting to discuss Guam, which no one had ever heard of. It is no more than sixteen miles long and maybe five, six miles wide. I know Guam well. It's not my favorite place, having been caught in 1976 in the second-worst typhoon in Guam history.

We had a meeting and decided to bid on the first prepaid health program on Guam. It was provable that a Filipino health insurance company was continually overcharging the government of Guam on coverage and payments, under the shifting sands of Pacific politics. Only about ten to twelve doctors practiced in Guam at that time, all Filipinos. I guess the government of Guam recognized the problem and decided to seek new bids. I don't know who else bid on it. We did.

Dr. Gumbiner, another executive, and I went to Guam. They considered our proposal for a day or two and then called me up one afternoon at the hotel and said we got it. Well, Dr. Gumbiner was jogging on the beach, and I'm not a jogger. Somehow I searched him out--I don't know whether I took a rickshaw [laughter]--but I got to him. We met with the officials and it was a very good contract, to provide health services to the 60,000 government of Guam employees, which included their families. The figure 60,000 is in my head; it might have been 80,000. There were only 120,000 on the whole island, and about 20,000 were American personnel at Anderson Air Force Base.

So now we had to set up new facilities, which Dr. Gumbiner arranged. We had to contract with a few doctors, which I did. It was very successful. Perhaps not right away, but it developed into over 80,000 members. This can be verified through the office. The one big clinic at that time was run by the Catholic church, which Dr. Gumbiner contracted with. It just worked out with proper planning. Dr. Gumbiner's main strength is planning and development.

Hughes: How did he know that the plan would be successful?

Schultz: That comes from Dr. Gumbiner's sixth sense. I can't say he knew it would be successful. I think he knows how to weigh the business potential. He has that gift. But there were big risks involved as well.

Hughes: Did he investigate thoroughly before he made the bid?

Schultz: Yes, as much as possible. I am sure he learned that the government was fed up with the practices and rising expenses caused by the existing doctors. Dr. Gumbiner doesn't plunge into a venture unthinkingly, so I think he investigated extensively. How extensively, I have no way of knowing. I went there five or six times, meeting with the insurance commissioner, signing up doctors, doing all the myriad chores to establish a new company. I never liked going to Guam, if only because you couldn't breathe there. The humidity was very difficult to contend with.

Hughes: Did FHP recruit people specifically to go to Guam, or did they shift people from the mainland?

Schultz: Maybe one or two old-timers were shifted to give some stability to the new center, but primarily we recruited.

Hughes: And was that successful?

Schultz: Yes. Our recruitment department did an outstanding job in recruiting for a rather remote island in the mid-Pacific.

Hughes: Guam represented quite a step in one sense, namely that up until that date, FHP had been strictly a southern California operation.

Schultz: Yes, right here, Long Beach and Orange County.

Hughes: Did the distance present problems in supervision?

Schultz: I was not in a medical supervisory capacity, but I would think so. Our medical director had that responsibility and operated very efficiently. Of course, there were employee turnover problems. In time, they were solved.

FHP in Utah, 1976

Hughes: FHP expanded to Utah in 1976, and in 1985 to Arizona and New Mexico.

Schultz: You've got to invest money to set up in a new area. It's not easy. You have to get permission from local authorities. It is very difficult to initiate in a new area which has different concepts of health insurance models. Some states assign HMOs to the department of insurance and others to the department concerned with corporations.

Hughes: What difference does that make?

Schultz: Oh, it's significant. Under the insurance law you have to put up tremendous reserves, like an insurance company. I'm talking about millions. You have to have it so that the state can seize it if you cannot pay any claims. You might run away to Mexico.

Another restriction of insurance law is on the sales of insurance. Now why was it held as insurance? Because the prepaid HMO does not indemnify you. Indemnify means if you put a claim in, the company pays you for what it costs you in line with the terms of the policy.

It's different with the prepaid plan. The membership fees are paid in advance. There's no indemnification procedure. You're assured the HMO has all the money it will receive at the beginning of the month--prepaid. No more money passes in that month from the insured to the HMO. There's no indemnification, which is at the heart of indemnity insurance. That's the basic difference. The HMO actually arranges the delivery of service and the financing, which is prepaid.

Hughes: Were you involved in the expansion to Utah?

Schultz: Oh, yes. Again, it's a testimony to Dr. Gumbiner's acumen in seizing opportunity. I recall Dr. Gumbiner and I were at an HMO conference of some kind in San Francisco. We went to a Chinese restaurant in Chinatown and we were standing in a line for a table and there were two women standing next to us. The waiter came over and said, "There's no table for two, but there's a table for four. Would you mind sitting together?" Well, why not? We might learn something, right? So we sat down with the ladies, and it turned out that one was in health administration and the other one was on the board of directors of the Salt Lake City HMO [Utah Group Health Plan].

The clinic was sponsored by the OEO [Office of Economic Opportunity]. There was government money involved in it, they were failing, and it was an opportunity to purchase a building very reasonably. That's what FHP did, although I've forgotten the details.

Hughes: Did you have anything to do with the Utah expansion?

Schultz: Yes. I handled the government aspects. I went to see some of the local politicians in Salt Lake City and secured permission for some kind of waivers. We hired a good local manager right away.

Health Maintenance Life Insurance Company

Hughes: Could you tell me about to Health Maintenance Life [HML]?

Schultz: Yes, I was the president of HML for a while.

Hughes: Well, you should know about it, then. [laughter]

Schultz: HML was a company created by FHP as an adjunct to sell regular (indemnity) insurance. It came under the insurance commissioner. You have to have a charter, you have to have a certificate of authority, policies approved--all very difficult.

HML was created to offer to the public dual choice: you want to buy a plan? Fine. If you don't want prepaid, then buy the HML insurance plan.

Hughes: Did HML pre-exist Guam?

Schultz: Yes.¹ We had two or three presidents of HML who didn't work out. You can't run an insurance company without a president. You must maintain records; you've got to have certification of premium collection, very detailed reports, and recognized insurance accounting principles.

Hughes: Why did he appoint you when your experience was not in insurance?

Schultz: Dr. Gumbiner thought it could be done easily and I was capable of doing it.

Hughes: It seems to me that HML played a specific role in Guam. There's a reference, for example, to the HML doctors threatening to resign en masse?²

Schultz: Yes. I was out of the picture by then, but I heard about that. There was a threat made. I don't know what it resulted in.

Hughes: What was the fundamental reason for having a prepaid plan?

Schultz: I think it was a testament to Dr. Gumbiner's imagination and ingenuity. He wanted to make the plan available to the public.

Hughes: So it was basically a business-based decision.

¹HML was formed in 1973.

²[Guam] Pacific Daily News, September 24, 1977.

Schultz: Oh, absolutely. I don't think Dr. Gumbiner makes decisions other than business-based. I think what you see in front of you, the corporate offices here, the growth of the hospital, and the whole setup, it's got to be business-related. There's no question about that.

Hughes: Were there ever accusations of conflict? If Dr. Gumbiner and others were crusading for prepaid group medicine--

Schultz: He wasn't crusading.

Hughes: --wasn't it a conflict to have a conventional insurance company operated by the same entity?

Schultz: No. It was all separate legal sanctions, all separate accounting procedures, separate sections, separate employees. It was never commingled. It was a separate and distinct company. I saw to that as well. I wasn't going to be the president of any facade.

Hughes: I meant a conceptual conflict. If you are a firm advocate for prepaid group medicine, having a conventional insurance company could be seen as a contradiction in terms.

Schultz: It can be seen as that. It can also be seen as a very innovative way to market a health product. A customer doesn't like a blue car, so you can sell him a green or white car.

The other big thing I left out because I was gone by 1985 was FHP's conversion to a profit-making corporation. I know little about that except the stock developed profitably.

Hughes: What was the reason for conversion?

Schultz: I am sure it was to build a stronger company with the infusion of additional capital.

The HMO Concept

Schultz: We had the tenor of the times in our favor in those days, because the federal government was slowly recognizing the value of HMOs. That's why there are over five hundred now. There are almost forty-five million members of HMOs in the country. FHP has marketing people out every day.

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Schultz: Millions of patients moved to the HMO system. They're not all happy. But they're all there by choice and signed the enrollment agreement. In the HMO Act of 1973 was the mandate that every company in America that had more than twenty-five employees had to offer an HMO to their employees, if there was one in their service area. So the employees were given a choice. We were allowed to come in and make a pitch on the benefits of prepayment. You can never say superior service; you can't say our Dr. Jones is better than Dr. Smith. But you can talk in general terms of some specific advantages, and let the employee choose. Studies show that the wife makes the decision. The husband gets the material from the plant, takes it home to decide within thirty days. The wife makes the choice. They have to make a conscious choice to get out of the fee-for-service system they were brought up on. It's an amazing development. Forty-five million people, which includes all the families, have chosen HMOs. It's an amazing figure, continually increasing. Patients are not all happy, I'm sure. Some HMOs are good; some are bad. The worse you are, the more you're investigated by the Health Care Finance Administration [HCFA]. It asks to see your marketing methods, your health care delivery system, is there a doctor there all the time? The law reads that service must be available "twenty-four hours a day, seven days a week." The qualification process is very difficult. The applicant HMO must produce several giant notebooks.

Hughes: On what sorts of things?

Schultz: Oh, health delivery system, finances, marketing, legal entities, organizational entities--all the basics.

Hughes: Were you involved with that process?

Schultz: Oh, yes, we all had a piece in those books.

Hughes: How often was qualification reviewed?

Schultz: Once an HMO is qualified, HCFA is supposed to come out periodically, depending on the size and success of the HMO. I'm sure Kaiser gets reviewed every three years. FHP might be every three years now. I'm guessing on that.

Hughes: An HMO has to go through the whole qualification process each time?

Schultz: HCFA has its own process, its own questions. It sends a team out, a doctor, nurse, finance man, marketing expert, et cetera. It spends about three, four days. Then it gives you an exit

interview, and it tells you what's wrong and what's right. You get a letter, and get thirty days to correct it.

Dr. Gumbiner as a Personality

Hughes: Tell me about working with Dr. Gumbiner.

Schultz: Well, Dr. Gumbiner is an astute man who practices the basic principles of quality management which have proven successful. He's very strict on information systems. There was a time when he was going to UCLA a couple of nights a week to get certification in a special management systems course. It was a well-regarded course. It had to be a tough drive up to UCLA at five o'clock two or three nights a week. Being medically trained, he's able to translate physician efficacy into systems.

The average fee-for-service doctor, what does he know about systems? Some people thought he was too business-oriented. Well, each man lives his own life his own way, the way you're fashioned. But it proved successful. You can't argue with success.

Hughes: Were you given free rein?

Schultz: No, it was delegated; I used my own judgment. I reported just to Dr. Gumbiner. He was the one that engaged me, so I reported to him.

Hughes: How would you characterize Dr. Gumbiner as an administrator?

Schultz: Great. Quick, sometimes brusque, not always right. But who's always right?

Hughes: Would he listen to you if you had an opposing viewpoint?

Schultz: He would listen.

Hughes: That's about all?

Schultz: Well, he's a fair man, but he's strong-minded and usually correct in his business appraisal. I wasn't satisfied with my salary.

Hughes: Is that why you left?

Schultz: Yes, the only reason. I've met Dr. Gumbiner since then, and we've spoken about that.

- Hughes: You asked for more money and he didn't want to give it to you?
- Schultz: Well, at that time I was doing five or six jobs and getting paid for less than that. But that's all history now. Had the financial terms been more favorable and equitable for me, I would not have left.

Traveling for FHP

- Schultz: I made a lot of trips for Dr. Gumbiner to different parts of the country, which I've always enjoyed--a lot of meetings and conventions. I arranged a speaking tour in Europe on HMOs.
- Hughes: That was in the eighties, wasn't it?
- Schultz: Yes, 1980 or '81. Dr. Gumbiner used me as a consultant for a period. I spoke on HMO systems at the London School of Economics several times.
- Hughes: How did that invitation come about?
- Schultz: Through Professor Brian Abel Smith, who was the original force behind the British National Health Service. He was kind of my sponsor there. And that led to many European engagements.
- Hughes: You always spoke on HMOs?
- Schultz: Yes, the application of HMO principles to health systems in different communities.

I should mention that many of my trips to Sacramento were to comply with the Knox-Keene Act which authorized the licensing of prepaid health programs in California. Mr. Knox was in the assembly for ten, twelve years, something like that.

- Hughes: He was the connection between our office and the FHP project. He called our office and suggested an oral history with Dr. Gumbiner.

Is there anything more you want to say about your years with FHP?

- Schultz: Well, they were good years. I did my part in helping the company along the way. I worked hard.
- Hughes: Well, I'm glad to have a chance to speak with you, Mr. Schultz.
- Schultz: Thank you.

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FHP Historical Highlights

- 1955 Plaza Medical Group
- 1961 Robert Gumbiner, M.D. converted his group medical practice--Plaza Medical Group in Long Beach, California--to a nonprofit corporation providing affordable, prepaid health services to 2,000 patients of Plaza.
- 1966 Plaza Medical Group disbanded. FHP became 100 percent prepaid.
- 1967 Membership was approaching 10,000 and a second FHP medical center (Central) opened in downtown Long Beach.
- 1968 Service expanded to Orange County, California with the opening of a new medical center in Fountain Valley.
- 1969 FHP developed the pilot project for a prepaid Medicaid program in California; a prepaid prescription drug program was established.
- 1970 FHP established a prepaid dental program.
- 1971 In FHP's tenth anniversary year, membership reached 30,000. A fourth medical center opened in Compton, California and a staff manager development program was established.
- 1973 FHP introduced the first group practice prepayment program to the Pacific island of Guam and opened its fifth medical center in the city of Tamuning. Health Maintenance Life Insurance (HML), an indemnity plan, was formed to offer a wider range of FHP health care choices. Expansion in California progressed with the opening of a medical center in Santa Ana, the company's sixth.
- The HMO act of 1973, requiring large employers to offer an HMO as part of the benefits package, was passed by Congress.
- 1974 FHP's seventh medical center opened in Anaheim, California, and a 15,000 square foot corporate office building opened next to FHP's original medical center in Long Beach.
- 1976 FHP expanded into Utah with the acquisition of Utah Group Health Plan and added two medical centers in Salt Lake City and Midvale.

- 1977 FHP became a federally qualified health maintenance organization on July 29 and opened a public affairs office in Washington, D.C. later in the year.
- 1978 A new 22,000 square-foot medical center opened in Anaheim, California.
- 1979 Two primary care centers--in Laguna Hills, California and Ogden, Utah--opened, bringing the total number of centers to eleven.
- 1981 The Valley East Medical Center opened in Salt Lake City.
- 1982 FHP received a federal contract to develop a prepaid health care program for Medicare recipients--the first Medicare "risk contract" on the West Coast. FHP officially changed its name from Family Health Program to FHP, Inc.
- A 7,000 square-foot wing was added to the Anaheim Medical Center.
- 1983 The FHP Senior Plan was launched through the federal Medicare prepayment project. FHP converted the historic Hippodrome Skating Rink in Long Beach into a unique Senior Health Plan Center.
- 1984 The Davis Medical Center--FHP's fourteenth--opened in Layton, Utah. A specially designed Senior Center opened in Anaheim. With the development of a Senior Plan in San Pedro, California, FHP launched its first community-based provided system (individual practice association, or IPA).
- 1985 Three new medical centers--bringing the total to eighteen--opened in Downey, California, and in Provo and Salt Lake City (Redwood), Utah. IPA plans expanded into downtown Los Angeles, Santa Monica, and throughout the South Bay in California.
- FHP expanded into Arizona and New Mexico with IPA plans in the Phoenix and Albuquerque metropolitan areas.
- Corporate Headquarters moved to a new building in Fountain Valley, California, and California Regional Administrative Offices opened in Long Beach.
- FHP converted from nonprofit to for-profit status in November; the FHP Foundation was established.
- 1986 In February, FHP opened its first hospital, a 125-bed acute care facility, in Fountain Valley; Charter Community Hospital in

Hawaiian Gardens, California, became an FHP-managed facility in July,

The company was renamed FHP International Corporation and became publicly held (NASDAQ: FHPC) through its initial offering of common stock in July.

Guam was renamed the Asia Pacific region to reflect expansion into Saipan and Palau.

In California, Orange/Tustin and San Pedro become the nineteenth and twentieth medical centers. Senior Centers opened in Laguna Hills and Fountain Valley. IPA plans were added in the Mid-Wilshire section of Los Angeles and in Riverside County, California.

At the end of FHP's twenty-fifth year, commercial members totaled 150,000 and Senior Plan members, 47,000.

1987 As revenues hit \$300 million, Westcott W. Price III was named president of FHP and Dr. Gumbiner became chairman and chief executive officer. Membership grew by 20 percent, reaching 312,000.

The HML indemnity plan was replaced by the FHP Life Insurance Company. A plan for commercial retirees was developed, and a dental IPA plan was established.

The 26,000 square-foot Huntington Beach Senior Center opened in California; four new IPA plans were established. The Holladay Medical Center opened in Salt Lake City, bringing the total number of staff model medical centers to twenty-five. The first FHP medical center in the Arizona region opened in Mesa.

1988 By June 30, membership grew to 373,000; Senior Plan enrollment passed 100,000. New medical centers were built in California's Moreno Valley and Riverside, in Salt Lake City (West Valley), in Arizona (Mesa and Phoenix), and in New Mexico (West Mesa and Northeast). California IPA plans were established in Redondo Beach, San Bernardino, Redlands, North Hollywood, Arcadia, San Fernando, and Gardena.

1989 The 1989 fiscal year closed with 465,000 members, 44 medical and dental centers, and revenues of \$700 million. FHP International Corporation made a public stock offering in the spring, and the stock was split two-for-one in the fall. The company acquired a skilled nursing facility (SNF) in Westminster, California, and opened an optical lab in Cypress, California.

FHP introduced its own brand of over-the-counter pharmaceuticals, the Senior Dental Program, and a program for commercial group retirees called Golden Health Care.

Utah hit the 100,000 member mark and opened the Parkway Medical and Dental Center in Orem. Arizona established new IPA plans in Tucson. New Mexico opened its Southwest and Southeast Medical Centers.

In California, the 25,000 square-foot Downey Senior Center opened; the region's Senior Plan membership grew to 100,000. Medical centers opened in North Torrance and North Long Beach, and IPA plans were established in Pasadena, Pomona, Lake Elsinore, Inglewood, Chino, and Glendale.

1990 Membership hit 500,000 in January. The 1990 fiscal year closed with a 40 percent increase in revenue, to \$980.4 million, and 548,000 members.

A new 33,000 square-foot medical and dental center opened in Ogden, Utah, and plans for a South Salt Lake City hospital were announced. FHP brought twenty-seven acres of land in Mesa, Arizona, for a medical campus and opened new medical centers in Phoenix and Tucson. In New Mexico, nineteen acres of land were purchased in northeast Albuquerque and a new IPA plan was established in Santa Fe. New Mexico's first FHP pharmacy opened at the Southeast Medical Center.

A second skilled nursing facility was acquired in Norwalk, California, and construction began on a 125-bed addition to FHP Hospital in Fountain Valley. A Central Laboratory opened in Fountain Valley. New IPA plans were established in San Diego, California.

Westcott W. Price III became chief Executive Officer and Pat Vitacolonna, a senior vice president, was appointed chief operating officer and executive vice president. Dr. Gumbiner remained chairman of the board.

1991 FHP celebrates its thirtieth anniversary.

Ultralink, an FHP-managed national network of affiliated HMOs was introduced. Also introduced were a Preferred Provider Organization (PPO), allowing members to select from a large directory of affiliated private practice physicians, Senior Advantage, a "Medi-gap" indemnity insurance policy for Medicare beneficiaries, and Worker's Comp, a workers compensation program for employers.

BIOGRAPHY

ROBERT GUMBINER, M.D.

April 1991

Robert Gumbiner, M.D., received a Bachelor of Science and a Medical Doctor degree from Indiana University in 1948.

After coming to California in 1950, he started in solo general practice in Long Beach, California and quickly progressed (1955) into building a ten-doctor medical group where he was a senior partner.

In 1960, dissatisfied with the current fee-for-service system of practicing medicine, he established what was then called a Group Practice Prepayment Program (GPPP) known as Family Health Program, which subsequently became FHP, Inc. This original GPPP was confined to the individual patients of the Plaza Medical Group where he was a Senior Partner. This service was then extended and the group acquired group contracts with the Long Beach Unified School District, the City of Long Beach, the State of California and the Federal employees.

In 1966 the organization evolved into a totally prepaid group practice and discontinued fee-for-service.

In 1969, Dr. Gumbiner managed, after two years of negotiations, to put together the first prepayment plan for Medicaid, or Medi-Cal as it was known in the State of California. This not only was the first in California but the first in the country and included doctors' care, hospital care, dental and psychiatric care.

After the company had established the Medi-Cal prepayment program, they began their very successful dental program component and their Department of Human Resources. The Department of Human Resources, which was a combination of psychiatric care, psychiatric social work, social services and home health, was developed as a result of a grant from HMOS regarding manpower development in health.

Dr. Gumbiner was invited to Guam to consult on the Guam Memorial Hospital and the health care system on that island. His recommendation was that the island did not need a new hospital, but rather needed a reorganized health care system. Eventually, in 1973, FHP was established on Guam where the organization acquired the Catholic Medical Center and provided care for the Government of Guam employees, federal employees and other groups on the island. At that time FHP not only established a staff model on Guam but in 1974 established the first IPA under a dual choice subsidiary insurance company HML Life Insurance Company, for the non-staff model doctors on Guam. This experience in the early 1970s was important in the development of both the staff and IPA models in the future.

The organization in 1976 then expanded to Utah by acquiring Utah Group Health Plan and enlarging that program in Salt Lake City to the whole Wasatch Front area.

In 1980, FHP, a non-profit organization, decided to convert to a hospital based operation in the State of California and negotiated a bond issue through the California Health Facilities Act for \$27 million to construct their first hospital in Fountain Valley, California.

Responding to a need for more rapid expansion and more capital, the organization converted in November of 1985 from a not-for-profit HMO to a for-profit organization. In 1986, FHP Inc. created the FHP Foundation, a \$50 million not-for-profit corporation, which received the proceeds of the buyout from the State of California by management

of the not-for-profit HMO. The FHP Foundation to date has given over 200 grants totalling \$8.5 Million, with a commitment for another \$1.17 Million through 1995.

The next step in the evolution of the organization was an initial public offering in July of 1986 at \$12.00 per share, which raised \$23 Million, allowing the organization to pay off its hospital bond and build new health care facilities.

In 1986 the organization expanded to Phoenix, Arizona and Albuquerque, New Mexico. After acquiring in these two regions, the organization moved into a new mode. An extensive IPA network supported by the staff model had already been created in California, and with the acquisition of New Mexico and Arizona, FHP developed an IPA network with staff model units imbedded in that network to give it strength, stability and the capacity to provide physicians who might be needed geographically or by specialty, thus establishing a truly managed health care system for those areas. Local hospitals were contracted with on a per diem or a capitation basis of payment.

Meanwhile back in California, in 1986 FHP acquired a second hospital which was to be totally remodeled to bring it up to the FHP standard. This included the use of landscaping to help bring the outdoors inside, the use of artwork and other decorative features, an executive chef and, most important, the concept of running a hospital like any other organization in a service related business (hotels and restaurants) in addition to providing quality care.

In the stock market crash of October 1987, FHP stock dropped from the initial public offering price of \$12.00 a share to around \$6.00 a share. Shortly thereafter FHP repurchased three million shares from the original shareholders and the public in a "Dutch Tender Auction." This was very successful and about a year later, in May of 1989, FHP did a public offering in which they sold three million shares for \$23.75 a

share. The stock then moved up to over \$50.00 a share and when it settled back to \$44.00 a share (December 1989) it was split to \$22.00 a share.

Recently, in April 1991, FHP paid a 10% stock dividend and the stock moved up to \$29.00 a share.

Since 1977 FHP has been active in the public affairs area and has maintained an employees PAC and a Washington, D. C. office. FHP was responsible for legislation in late 1970s that exempted HMO hospitals from the Certificate of Need, thus allowing HMOs to expand and to shake-off the grip of old fashioned fee-for-service hospitals and their wasteful ways. In addition, Robert Gumbiner was a major contributor to the HMO Act of 1973, as well as the California enabling legislation for HMOs in 1980.

While developing FHP from a ten-doctor medical group to an organization employing 9,000 people, with over 50 medical centers and four hospitals in five states and doing over \$1 Billion a year in revenue, Dr. Gumbiner developed several unique approaches in management. These included a true matrix management system, staff development programs, doctor/management programs and other systems to contain costs, eliminate waste and produce the most care for the most people. These management concepts are the cornerstones as to why FHP has always been able to grow (by using its own capital) and to be fiscally sound, innovative with physician and management staffing in-depth.

In summary, Robert Gumbiner has had the experience of a solo private practitioner, a senior partner and founder of a fee-for-service group practice, the founder and developer of a not-for-profit HMO, applied and received a not-for-profit bond issue, converted a HMO from not-for-profit to for-profit and has been successful in taking it public with several public offerings.

In addition, throughout his career he has acted in all capacities in the HMO field from Marketing Director, Medical Director, Executive Director, Chief Operating Officer, Financial Officer and finally to Chief Executive Officer. At the same time he has maintained a keen interest in other health care delivery systems. On two different occasions he studied the British system and a paper he wrote on the British general practice sector was published in the Journal of the California Medical Association in 1973. He found time to write a book in 1977, "HMO - Putting It All Together" that was published by C. V. Moseby & Company. Most recently he has studied the Scandinavian health care system.

Having retired from FHP as CEO in November of 1990, he now finds himself free to participate more fully in public service. With his depth of experience in all phases of the United States health care system, as well as his knowledge of foreign health care systems, he would be a valuable resource in regard to the upcoming reshaping of the United States health care system and the many first world health care systems that are now suffering from cost-overruns, poor productivity and manpower dislocations.

RG:cb

April 10, 1991

**CHRONOLOGICAL NARRATIVE
ON THE BACKGROUND & EXPERIENCE
OF ROBERT GUMBINER, M.D
FOUNDER, FORMER CHIEF EXECUTIVE & PRESENT CHAIRMAN OF
FHP, INTERNATIONAL CORPORATION**

April 1991

Dr. Gumbiner graduated from Indiana University School of Medicine in 1948 and following postgraduate work at Indianapolis City Hospital, moved to Southern California in 1950. During the next few years he worked in industrial medicine, public health and group practice prepayment medicine as doctor/manager of a prepaid medical clinic in San Pedro.

In the early 1950s, after spending two years in solo general practice, he started the Plaza Medical Group, a fee-for-service group practice. In 1955 he began experimenting with the prepayment of services through this medical group to those individual families in that practice who wished to pay on a monthly prepayment basis rather than a fee-for-service basis. The medical group then began covering not only their medical services, but hospital services and prescription drugs.

Located in Long Beach, California, by 1966 this medical group consisted of ten physicians and had enrolled the Long Beach Unified School District and the City of Long Beach employees in group contracts, as well as continuing to carry their original 3,000 to 4,000 individual families under contracts. During that period, 1955 to 1966, the organization moved to about 50% group practice prepayment (as it was called then). In 1966 the group split up over the controversy as to whether they should become all prepayment or all fee-for-service. The majority of the doctors left the group and Robert Gumbiner continued by merging the Plaza Medical Group into the Family Health Program, which was the Group Practice Prepayment Program, or HMO.

This program then began to expand very rapidly and acquired two more sites in the Long Beach area.

In 1968 FHP developed the first pilot project for the State of California to provide care for Medi-Cal, or Medicaid as it is called in the rest of the country, on a prepayment basis. This was the first program in the nation to cover all services; that is doctors' services, hospital services, preventive services, psychiatric services, prescription drugs and dentistry.

By the late 1960s, the organization was 100% group practice prepayment and serviced the State of California employees, the federal employees, many industrial groups, the Medi-Cal program and several local city and school district programs. During that period Dr. Gumbiner acted in various capacities; Medical Director, Marketing Director, Chief Financial Officer, Operations Director, medical center developer/planner and Chief Executive.

He was involved heavily in the lobbying for Medicare in 1965-1966 and also in the HMO Act of 1973. In addition, in the mid-1970s, FHP, through its Washington office, sponsored legislation that was eventually passed which exempted HMO hospitals from the Certificate of Need requirements.

In 1973 Robert Gumbiner was asked to review the state of medical care on the Island of Guam and shortly thereafter was asked to come to Guam and institute a health care program for the entire territory. This was done successfully and FHP took over the Catholic Medical Center and helped to negotiate the many and difficult problems of the new Guam Memorial Catholic Hospital. This was an example of taking an isolated, poorly serviced fee-for-service market and turning it into now what is almost 100% prepayment while creating extensive improvements in access, quality and control of health care costs. FHP not only put in a staff model HMO in Guam, but also instituted

an IPA, which stimulated the government to start a rival HMO that was eventually sold to private industry. Now the entire island of some 100,000 people appear to be totally covered by prepaid managed care.

In 1976 FHP took over the management of the failing Utah Group Health in Salt Lake City, merging it into FHP in California. This program was turned around into a successful operation throughout the Wasatch Front.

FHP opened facilities and units in Arizona and New Mexico in 1986. By this time the organization had expanded the IPA component, as well as continuing with the original staff model mode. This is unique to FHP in that the staff model supports the IPA and provides the access and the service capacity wherever it is needed, thus strengthening and stabilizing the IPA. Robert Gumbiner had the experience of starting the initial IPA in Guam in the early 1960s and this experience was transferred to IPA units established in the periphery of the California staff model region, as well as the mixed IPA staff model in Arizona and New Mexico.

Robert Gumbiner has written several articles on managing health care, as well a book entitled "HMO - Putting It All Together" in the 1970s.

In conclusion, Robert Gumbiner has had a depth of experience seldom seen in this country, which included the practice of fee-for-service medicine, both solo and group, the building of a fee-for-service group practice, founding and developing a successful staff model HMO and an IPA model HMO in the most highly competitive area of the country, Los Angeles/Southern California metropolitan area, plus in isolated rural areas such as Guam.

On the finance and development side, Robert Gumbiner initiated and successfully concluded a bond issue through the California Health Facilities Act while FHP was still

not-for-profit in order to build their first hospital in Fountain Valley. Subsequent to that he spearheaded the conversion of FHP to a for-profit company to enable the company greater access to capital for their growing needs.

In July of 1986 he was involved in the initial public offering of FHP at a stock price of \$12.00 a share, which enabled the company to pay off their bond issue for the hospital and provide additional working capital. During the October 1987 stock market recession, FHP negotiated a Dutch Tender offer which allowed the company to buy back three million shares of its stock at \$6.00 a share. Approximately a year later the company went out with a new primary/secondary offering, selling the stock it bought for \$6.00 a share for \$23.75 a share. Since that time the company has had a steady increase in its stock price, did a stock split in 1988 and in early 1991 declared a 10% stock dividend. In 1991 FHP also conducted another successful primary/secondary offering to raise additional capital for the company.

The company is now doubling its hospital size in Fountain Valley, California and has acquired management of another acute hospital in Northern Long Beach, as well as and two skilled nursing facilities. A hospital is about to break ground for construction in Salt Lake City, Utah and land has been acquired for a hospital site in Phoenix, Arizona and Albuquerque, New Mexico. The company has extended to San Diego and is considering extension to Northern California and other western states.

Under the guidance of Robert Gumbiner the company has made steady but careful progress under a planned strategy of growth and using innovative concepts. One of the innovative concepts was the first TEFRA risk contract for the delivery of Medicare on the West Coast, which is now the second largest Medicare enrollment in the country. This program charges no monthly premium and covers most catastrophic items; such as prescription drugs, preventive services and psychiatric care.

In addition, he has explored the health care systems in various countries around the world and had an article published on the British system in the Journal of California Medical Association and has recently consulted with the Swedish government's health planning council.

Robert Gumbiner retired as CEO in November, 1990, and he remains Chairman of the Board for FHP International, FHP, Inc. and FHP Foundation.

He now feels that he has some additional time for public service and, with his depth of experience in developing and operating managed health care systems, as well as financing them, he should be able to add considerable expertise to the upcoming debate on the national health care system in the United States.

RG:cb

April 10, 1991

Memorandum

To : All Hospitalizing Physicians

Date: May 5, 1981

From : Robert Gumbiner, M.D.

Subject: Controlling Hospital Costs

Hospital care costs have risen 44% in the last half of 1980 - while a specific charge, (i.e., CBC - Bed rate etc) may only have gone up 15% or 20%, additional service and technology or expensive drugs account for the rest. See attachment. i.e. intensity.


Robert Gumbiner, M.D.

RG:gs

Attachment

cc ad-med. Sec.
w/ste - inv - outside & de

HOSPITAL UTILIZATION PROCEDURES

The following is being written for the information of all hospitalizing physicians. Items mentioned herein have all been personal experiences of the author throughout the years in controlling hospital costs. Remember, we are not attempting to decrease the quality of care; we are attempting to control the costs, which will probably result in better care for the patient.

1. Time of Admission and Discharge

A patient should not be admitted on Friday for a Monday morning surgical case. Many times this occurs because the physician wishes to work the patient up and check them in on Friday as he is going to be gone Saturday and Sunday, coming home late Sunday night when he will not have time to do this. This is not the patient's fault or our problem. The patient should be admitted on Sunday night or Monday morning. You will either have to work the patient up yourself or arrange for the work-up to be done. Hospitals usually charge from 12:00 noon one day to 12:00 noon another day. Therefore, if you are tied up in the morning and do not get around to discharging your patient until 2:00 or 3:00 in the afternoon, they may be charged for another half day or about \$205. What is even worse is when the physician can't make it to discharge the patient before 12:00 noon, so he just lets the patient stay over another day at \$410, making evening rounds, and signing the discharge order then for the next morning. Hospital bed days are averaging \$410 to \$550 a day.

2. Preliminary Work-Ups and Hospital Discharge

Remember that the patient is probably better off at home than in the hospital where they can catch somebody else's disease. Therefore, if the patient is ambulatory, can take care of himself, he does not belong in the hospital for the convenience of the physician. It is only too well known that many patients are in the hospital because it is more convenient for the physician to see his patients all together in the hospital than to make other arrangements to see them; such as, having them brought in by auto, ambulance, or even making house calls (heaven forbid!). Use of a good convalescent hospital, skilled or home health care is a fiscally viable alternative. An acute hospital bed day costs about \$580 to \$850 a day, overall. A convalescent hospital bed day costs about \$37 a day. If you move your patient for two days into the convalescent hospital instead of keeping them in the acute hospital, you're adding a \$75 ambulance charge to a hospital day. By simple arithmetic, that's \$120 versus the \$580 for one acute day. Our staff physicians can make arrangements to visit these patients in the

convalescent hospital. We always have a staff physician assigned to convalescent hospital rounds daily.

All necessary laboratory and x-ray work should be done on an ambulatory basis before the patient goes into the hospital! There could be minimum requirements that the hospital may require; such as blood count, urinalysis; but the rest of the work could be done and should be done ambulatory. Simply write the order and the FHP ambulatory care facility will get the work done. Not only do you save a hospital day room and board, but since FHP has the in-place facilities and technicians, the cost is very little to do another x-ray or laboratory procedure, whereas we are being charged on a retail unit basis in the hospital. The same thing goes for repeat x-ray/laboratory procedures after the patient leaves the hospital. Do not leave the patient in the hospital for another day or two simply to get some laboratory or x-ray work. Barium work and many other diagnostic procedures can be done in our medical centers after the patient has been discharged. Remember, acute hospital care is for the horizontal patient who is not ambulatory, cannot help themselves and is in need of nursing care. Upper GI cost over \$100 each.

3. Timeliness of Procedure

If the patient is hospitalized and you are ordering a barium enema for the next morning, make sure that the barium enema is done that next morning. Do not take the radiologist's excuse that he could only do six that morning and he had an emergency so your patient has to wait another day. Instead of the barium enema costing \$75 to \$85, it then would cost \$375 to \$385. You have to add the daily rate onto it. One of our nurse coordinator's jobs is to make sure this does not happen and to make sure that the procedures are timely. Just a note of warning, do not write "stat" orders unless you need the information immediately and you are going to use that information immediately! Stat means that the lab will drop everything they are doing, immediately obtain the specimen, run the report for you and get it back to you immediately. This usually costs FHP between 50 to 100 percent more. Be sure that you time your orders. Not only for medical/legal purposes you should note the date and time you write the order, but for financial reasons. In some hospitals the patient is charged 25 percent extra if the x-ray/laboratory work is done outside of the routine patient care times; that is, 7:00 a.m. to 3:00 p.m. You might write the order before the work day is done but we might be charged an additional 25 percent if the hospital says that the order was actually written after the work day. Also, you would not like to have some attorney claim you wrote an order that could have saved a patient's life five minutes before the patient dies when, in reality, you wrote an order several hours beforehand. Always have a treatment plan and make sure it is carried out by the hospital personnel.

4. Appropriateness of X-ray and Laboratory Work in the Hospital

Diagnoses are seldom made solely on the basis of laboratory work. Excessive laboratory work doesn't do anybody any good except the laboratory in the hospital. The same thing for x-ray and the patient gets extra radiation. Watch out for the radiologist who likes to build up his income by suggesting additional views. There have been radiologists who have been known to always suggest additional views for every procedure you ever ordered and even several additional procedures. Thus, instead of \$50 worth of x-rays, the patient ends up with \$150 or \$250 worth. If you are the attending physician, it is up to you to decide whether the patient needs some extra views of the chest or not. If your decision is logical, don't worry about liability.

5. Central Supply

You will be in for a confusing, frustrating time when you take a look at some of your patient's central supply bills. I dare you to figure out what they are all about! For instance, a box of Kotex provided for a woman in the hospital probably costs about three times as much as she could buy it for at the drug store. When you hang up a bottle of five percent glucose and water, it will probably cost your patient between \$50 and \$60. They charge for the fluid, the tubing, the pump and the regulator - all separate. If you decided, after they get about 100cc. that you want to change it, then that is wasted. You can be sure that such a bottle of solution can be purchased with tubing for only a few dollars from the supply house, but your patient is going to be charged \$50 or \$60. In addition, every time you open a pack to take out a bandaid, the patient is going to be charged \$25. If you want one glove for a rectal, they are going to get charged for a pair (2) disposable gloves and so on and so on.

6. Pharmacy

Hospital pharmacies usually use the highest possible rate sheet or schedule they can. It is usually from 100% to 400% more than the patient is charged for the same thing at the corner drug store. Actually it is seven times the cost; a 700% mark-up! If you decide to change medications, then order a "DC" on the medication. Instruct the floor to send the medication back to the pharmacy and credit the patient. We have seen examples of several different medications running on and on when the doctor thought he had discontinued them. They may bring up a week's supply. Use only the appropriate medications. Medications are very expensive. Don't give medications "IM" or "IV" when it can be given by mouth. An injection of iron will cost your patient \$10 to \$20 and the same thing taken by mouth will cost them a few cents. Some prescription IV's are as much as \$25 a dose. Do not order take home drugs from the hospital pharmacy. Have patient's family pick them up at the FHP center before discharge.

7. Discharge Plan

Be sure you have a discharge plan where the patient can either go home, go to a skilled nursing home or to some other facility. Make sure that the patient knows what they are supposed to do at home, assistance is available through DHR. A soft diet to some patients means many different things. "Take it easy" means other things. Discharge planning nurse or FHP coordinator can help out in this area. Remember, the patient should not receive take-home drugs. We have seen patients stop at the pharmacy and pick up \$200 worth of drugs to take home (which should really be paid for on an ambulatory basis) and in the case of FHP, they can get them on a generic basis from our pharmacy for much less cost, perhaps ten percent, of what they would pay in the hospital. If you want an interesting time, go over a patient's hospital bill and try to figure out the pharmacy - you won't believe it. Discharge plans should be made upon admission.

8. Physical Therapy

If you want physical therapy, specify exactly the orders you want. Don't leave it up to the physical therapist, who is getting paid by the modality. He or she may input three different modalities, getting paid \$20 each, and the patient doesn't need them. We have seen instances when the doctor ordered heat to the patient's back and instead of getting an electric pad costing \$10 from the nursing service, they had physical therapy drag up some machinery and charge the patient \$15. The same thing applies for teaching the patient to use crutches. Physical therapy comes up and charges them \$15 for crutch-walking exercises when the nurse should have done it as part of the service at no extra charge.

9. Miscellaneous

Be sure and time your OR time in your surgery report. Many times the surgeon is in the OR one hour and we get charged for three hours. The same thing applies for anesthesia time. Sometimes the anesthetist starts charging us when he has his first morning cup of coffee and finishes charging us when the patient leaves the recovery room. However, he has three patients in that recovery room simultaneously and he is charging them all for his time, each on an hourly rate. By helping FHP control hospital costs, you will be helping yourself. If health care money goes into unnecessary hospital costs, there will be less left for you, the doctor, and you will get the blame for rising costs. In the final analysis, take a look at some of your patients' bills (ask them to bring them in) and you will be surprised.

Incidentally, if you need another specialist (a different specialty) refer to the attending physician from FHP and we will make arrangements for a specialist we are using or a specialist on our staff.

POSITION PAPERFHP POLICY, ATTITUDES AND MANAGEMENT OBJECTIVES
THAT HAVE RESULTED IN SUCCESS

by

Robert Gumbiner, M.D., President

- I. Adheres to management theory, especially
 - A. Goal oriented business management by objectives rather than people oriented as in the medical field, public health and welfare.
 - B. Invest in the development of management people.
- II. Cost Consciousness
 - A. Provides the most for the most consumers. Let others provide the specialized and low utilization services.
 - B. Pay attention to quality as well as quantity. Get the maximum work out of the doctors, dentists, secretaries and everybody else - attention to objective systems.
 - C. Demand documentation for all expenditures.
- III. Innovation in a Conservative Manner
 - A. Take a calculated risk only if it makes economic sense.
 - B. No emotional decisions.
- IV. Marketing Consciousness
 - A. Go where others are not.
 - B. Stay ahead of the market.
 - C. Research first but move with only the necessary input.
- V. Resistance to Outside Pressure and Intimidation
 - A. Objectivity in decision making.
 - B. Resist emotionality.
 - C. Require proof.
 - D. Do not accept bureaucratic opinion as the law or regulation.
- VI. Lever Capital Investment
 - A. Invest in people and variable costs.

- B. Keep capital investment to a minimum.
- C. Remain heavy in liquid assets and continue to reserve.

VII. Move Only on a Planned Approach

- A. Hold individuals accountable - no excuses
- B. Do not deviate from plan without documented reasons.

VIII. Growth

- A. Controlled as to speed and amount.
- B. Direction - Geographic, sector and market
- C. Planned - Adhere to plan

IX. Innovation

- A. Objective, not emotional.
- B. Into specialized, non-competitive markets.

X. Financial Viability

- A. Independence - Don't do it if we lose control.
- B. Diversity of income.
- C. Planned budgetary expense.
- D. "Hard Nosed", tough-minded management (i.e., demand proof for explanation.

XI. Staff Development

- A. Top priority
- B. Stay slightly over-staffed
- C. Goal oriented

XII. Quality Oriented

- A. Level that can sell.
- B. Tell about it.

Memorandum

To : The Medical Department

Date: August 4, 1981

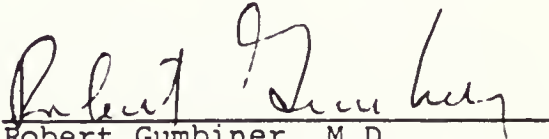
From : Dr. Gumbiner

Subject: MEDICAL SYSTEMS PROCEDURES

Please be advised that the following procedures will be followed in the future in the Medical Department.

1. The charts will be written up in the rooms and not in the doctor's lounge, and at the time the patient is seen.
2. There will be a new referral form. Part A will be a referral form and consultation report from the consulting physician and Part B will be a request for further treatment.
3. The page system will be used to page all patients to come in.
4. All patients will be pages by "Mr." or "Mrs.".
5. The bell and light system will be used.
6. All rooms will be set up according to the FHP modular concept.
7. There will be no phone refills of prescriptions. Each prescription will be have indicated how many refills.
8. All prescriptions will be called in on the Bogen. If there is no Bogen in the centers, install them.
9. No phone consultations will be made. The patient will either come in to see the doctor, or not come in. This is to avoid malpractice and appointment foul ups.
10. Nurse practitioners and P.A.'s will nothave scheduled times to consult with physicians. This will be done in down time between patients.
11. There will be no walk-in spots allocated. Walk ins will be scheduled in on an non-appointment clinic in the evening.
12. The FHP system of identical rooms, multi-purpose rooms will be used. There will be no rooms allocated for OB, adult medicine, general practitioner or pediatrics that are separate.
13. Doctors will use various nurses and various rooms.

14. We will use the tag system and board system in all areas.
15. Doctors will use general practitioners three or four rooms, internists two rooms, and schedules will be made appropriate to this.
16. Schedules will be made anticipating greated walk ins such as Monday and full schedules such as time of day. Doctors will be scheduled equally so that not everybody has Tuesday, Wednesday and Thursday afternoons off.
17. We will utilize split shifts if necessary and will institute this at two target centers.
18. There will be opening and closing schedules for all centers and people designated in charge, particularly on the week ends and evenings.


 Robert Gumbiner, M.D.

RG:jf

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FHP PHILOSOPHY
"Dr. Gumbinerisms"
March 1989

On Staffing ...

"The most important thing you can learn in management is to select the right people."

"Never stop recruiting, even if you're fully staffed."

"When a job defeats a number of people in a row, it is probably not that the people were wrong for the job; it is probably that the job is too big for one person."

"If you want to be a \$100 million company and are a \$10 million company, you had better have the management for a \$100 million company or you won't get there."

"In a growing company, 75% of the promotions should be from within and 25% from outside the company. It's better for morale and for the company."

"In the final analysis each person is responsible for his or her own destiny."

On General Management ...

"We are in a very complex industry - not just one aspect but many. We provide a risk program like an insurance company and a service like a hotel, restaurant or hospital. An industry this complex cannot survive without systems. Because the company keeps growing and is so complex, the systems must continually be re-evaluated and responsive, but they must be consistent."

"We will spend a nickel to make a dollar."

"We can lose money on one element of the program but make it up on another (e.g., we probably lose money on prescription drugs but if our members take their prescriptions and stay healthy, they may not cost us as many expensive hospital days)."

"FHP cannot be all things to all people."

"Physician time is our most important resource. Buildings and systems must be designed to maximize their efficiency."

"Some bureaucracy is necessary at the lower levels. You have to have bureaucracy because if you don't, you have anarchy. But if you get over a certain level of management you have to discard bureaucracy and get back into innovative, conceptual thinking."

"Systems are what make things work. A system has to be simple, first of all, so people can easily use it, remember how to use it, etc. Then you have to think of all the possibilities."

"Test the system, make sure it works."

On Products ...

"The HMO tries to give the most care to the most people for a finite amount of money. We do that by moving expensive in-patient care to the ambulatory setting and by not funneling our resources into non-productive high tech or exotic benefits."

"Pricing should be in the upper third of the market. Let the competition play the discounting game down the road to bankruptcy. Our service and facilities must justify the price."

"FHP is not a teaching institution. We don't need the very latest technology to deliver high quality medical care. We also are not a research institution."

The typical indemnity insurance does not guarantee availability of care or quality whereas the HMO goes that one step further and we provide the care and provide the availability and pay for it. The HMO may not allow you the benefit of going to any doctor or hospital anyplace but that is only a perceived benefit because in many areas, you only have a limited number of doctors available."

"We started FHP back in the middle 50's because we thought it was strange that the sicker a patient was, the more they had to pay, yet the less value they were to pay."

"Everyone talks about conflict of interest in medical and dental care. The truth is, the biggest conflict of interest that can possibly be in medical and dental care is the fee-for-service system. How can it be that ny dentist would be interested in preventive dentistry and eliminating all need for dentistry if the dentist is working on a fee-for-service system? So, we try to reverse the incentives and

set up a situation in the HMO where the physicians and other providers can treat the patients and be concerned with the healthcare without worrying about the cost to the patient, whether the patient can afford it or whether it is going to enhance or bear negatively on the provider's own income."

"Medicare monthly premiums for the risk contractor result in adverse selection (high utilization) and will never cover the cost. The cost of building, plus the cost of getting the individual off the program for non-payment is prohibitive. Premium for an HMO risk contractor is not to be compare to insurance company products which have a different benefit level."

"Sell what we have and don't be a "me too" product. We have evening hours, weekend hours, health education, employee assistance programs, mental health, prescription drugs in the same place. Communicate this. We are not an insurance company, which produces lower benefits and offers any doctor at any location."

On Service ...

"In marketing, first impressions are critical. First you see the building and the grounds and you get an impression. If the building and grounds are sloppy, you figure the doctors and nurses are sloppy."

"When you walk in, the first person you meet is critical, whether it is in the hospital or a medical center. That's when your marketing starts. The appearance of things, how people greet you, how you are checked in, escorted to your room, the little extra things."

"Every little detail in service counts."

"Everybody who meets one of our patients or consumers, including the doctor, is marketing."

"Our member comes first. Knowing what is on the member's mind is everyone's job."

"The quality of our service and products is what our members says it is."

"It is better to keep a member than to find a new one."

"Supply the most care to the most people - not extensive/expensive care to one and none to the others."

"In order to get productivity you must have systems; in order to make systems work you must have standard facilities design."

"Absence of adequate systems of long term care results in increasing utilization of acute hospital care."

On Decision Making ...

"If you find a manager that never gets into a problem, that's probably a manager who never tried anything new or different because 50% of the stuff you try that is new and different is going to get fouled up. And like the guy said, 'If I was right 51% of the time I'd be a total winner.'"

"We are more interested in the people that get it on the road, get it started and how they repair it when they get in trouble. That's the measure of a manager."

"Get the right amount of information to make a decision - not too much, not too little - so as not to miss a 'window of opportunity.'"

"Information should be on time, in a format you can understand, is reasonably accurate and it should only be the information that is important."

"When a problem needs prompt attention, do it now and repair it later."

"I think if there is one major obstacle to managing it is indecisiveness. Managers are supposed to make decisions, however, many don't because they have a high anxiety level. They are usually afraid of being ridiculed and afraid of failure. I think people who have a high anxiety level don't understand that 50% of the time they are going to be wrong anyhow, and that's okay if they learn from the experience."

"We are seeking managers who are decisive, fearless, aggressive and who can make decisions with a minimum of information while at the same time are able to look behind the obvious and obtain the necessary information to make reasonably accurate decisions. We are looking for bright, get it done type of individuals who can cull out the right amount of information, operate quickly and who do not go off impetuously without critical facts."

"Reluctance or inability to deal with the problem of the living dead, the lingering terminal or the marginally salvageable preemie will eventually bankrupt the system."

On Cost Control ...

"To survive there is supposed to be more revenue than expenses. A lot of people don't get that."

"Cost control is not keeping people from getting what they are supposed to get; cost control is eliminating the waste. Waste is someone using a \$4 paper drape to clean up a spill when a 4 cent paper towel was available. This results from people not being aware of what things cost and the impact of waste on their jobs."

"Equipment - use it up, wear it out, make it to."

"Absence of access to prescription drug coverage in Medicare results in greater ambulatory and hospital utilization (large deductibles, \$500, does not constitute access to prescription drug coverage).

On Matrix ...

"The matrix system gives the needed back-up and depth of management. It provides trained replacement. It provides shared opinions since one person's opinion may be erroneous. It also protects the inter-sender from somebody who may be prejudiced against their performance and gives them an extra resource to draw upon."

"It takes about twice as much management to run a matrix, but that's alright because if you are in a fast growing organization you need two or three times the management than you would if you weren't. Why? Because everything you do in a growth organization is new or different. If it is new and different it takes twice as long to do than if it were the same old thing. Thus, matrix fits in well with a fast growing organization. The stretch theory doesn't work. "

"The matrix promotes turmoil but when all is said and done, the organization is stronger and less falls between the cracks."

On Planning ...

"When a company is young and flexible it can change direction at a moments notice (like a speed boat), but as you get older, bigger and more sophisticated you can't make changes that quickly (like a freighter). Therefore, your planning must be better."

"A plan is worthless without plans for contingencies. The older you get the more you realize that things seldom go right."

"Planning has to be continuous. It doesn't do any good just to make a plan and forget it."

"Luck is preparation meeting opportunity."

Board of Directors ...

"Never put practicing attorneys, accountants, bankers or physician on a board unless they are first a manager."

"Never have two people on your board that are on another board together."

CS:cb March 16, 1989

PHILOSOPHY OF FHP, INC.

FHP is a production organization, not a research or not a teaching organization.

FHP is a marketing organization since without consumers to take care of we lose our reason to exist.

We must project a quality image since we cannot be the largest HMO in Southern California, nor can we be the lowest priced.

We must eliminate waste since money saved in this manner drops right to the bottom line, allowing us more funds for salary increases, new equipment and facilities, etc. However, watch being "penny wise and pound foolish" - do not hire an Assistant because you have to do it all yourself and then you are your own Assistant.

Things always change and must be responsive to the environment. Our policies and procedures will always change.

Supervision should have the highest priority (i.e., learning supervision and practicing supervision). This means letting people know exactly what you expect from them, feedback if they understand you, coaching, sharing, and emotional support. Some of our departments are like a football team without a coach.

Communication is one of the most important elements of management. It can be done by memo, face-to-face, or by meetings. The best way is through meetings, however, they must be well structured, have the right people there, resulting in a decision with a time and a person.

Tape

RG:cb

MEDICARE PROGRAM

A paper written on the history of the Medicare program (the history and the efforts in doctor recruiting) would be of value to new people coming on board like Robert Licht and Bill Price. Also, an explanation of the three circles in the three areas that make an HMO "go."

The theory of the three circles. Running an HMO is very much like running a three ring circus. First, we have the problem of marketing, and at the right price. Second, we have recruiting and orientation of the providers that produce the service. Third, we must have facilities to provide the services in.

If we market and we are not able to take care of people because we do not have the doctors or facilities, we will permanently wreck our marketing and be known as providing poor quality.

If, on the other hand, we recruit physicians and they have no place to practice in (one or two rooms apiece), it would cause great discontent among our physicians, as well as cut down their productivity, and therefore patients would have to wait (i.e., marketing problems).

We will go bankrupt supporting excess facilities if we do not have the market and the income. If we recruit doctors and do not have the income, the same thing happens.

It then becomes very obvious that these items must be coordinated. The interesting thing about the Group Practice Prepayment HMO is that if we market vigorously at first, and we know we have the market locked up to come in at a certain time, we can then recruit the doctors to that market and we can use temporary facilities for awhile. The problem is that it takes longer to build facilities than it does to recruit doctors. The HMO can get doctors (fill-ins), if they have to, or they can get internists, pediatricians, and general practitioners and then hire outside specialists. However, marketing takes a while to develop and you can never stop it - if you slow it down you go backwards. So, once you "rev" up the market you have to keep moving forward with the marketing. Therefore, it is critical in the planning of

Medicare Program
Page Two

facilities and doctors that they are coordinated.

In summary, the most significant thing is marketing, accuracy in pricing, and predicting utilization.

The next most significant item is recruiting your doctors, and this may take up to six months to get certain specialities.

Next are the facilities. The plan should be prepared so that we can be positioning ourselves with either land purchase or architecture ready to go; the construction time can then move.

There is one other factor entering into this since we have gotten larger; that is the need for money since it has become necessary to build larger facilities. This makes banking relationships very important. Due to the prepayment nature of our business, this should be pretty easy.

Tape

RG:cb

Typed 12/6/82

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FHP'S
HISTORY OF PHYSICIAN RECRUITING

by
Robert Gumbiner, M.D., President

When we first started recruiting, 20 years ago, this was done from my desk with the help of one secretary or the Medical Group Manager. I would design and put the ads in, answer the letters, talk to the doctors when they came through, etc. We needed almost no expensive recruiting such as mass mailing or long distance telephone calls, and it was all done through medical journals.

It soon became obvious that the type of people who look in medical journals for a job are either very young doctors coming out of school or are doctors out of a job and are "foot loose and fancy free" for some reason or another. Doctors who are set in a practice (who are the ones that you really want) do not look in the back of a journal.

We then started advertising at conventions, with the idea that doctors who go to conventions might be experienced doctors. We soon realized here that 20 percent of the doctors go to 80 percent of the postgraduate work so they do not get volume prospecting this way.

During this period of time we also experimented with trying to identify what type of doctors would be best suited for an HMO. After much discussion with the human factors people at UCLA, it became obvious that we could not identify these doctors but that they would have to identify themselves. It was therefore decided to set up a model that would automatically attract or reject the type of doctor that we were looking for. Thus, if we were looking for mature successful physicians, who wanted freedom from administrative problems and the vicissitudes of practice, we would have to build an organization that would attract them. Therefore, we began building in the longer vacations, an automobile allowance, the sabbatical, a pension program, etc. - all things they could never get in private practice.

It became obvious that we could not compete for doctors with money alone. Any doctor that wished to work long hard hours could make a greater gross amount per year than we could ever pay them for working eight hours a day and being on call once a week. Later on we came to understand that recruiting physicians was just like marketing the program, the only difference being that we were selling our program to the doctors.

We then made different types of brochures (like university recruiting), we continued to go to conventions, advertise in magazines, but we took another step - we established a Recruiting Department and went into direct mail. Direct mail was highly successful in getting answers, but it was expensive. Out of 20,000 mailouts, we would probably get 200 answers, but out of these at least two-thirds to three-quarters were people we did not want (foreign graduates, alcoholics, people that had serious problems, etc.). Out of the balance (50 if we were lucky) we might, over a period of time, get 10 or 15 to come in for an interview, half of whom would not want us and the other half we might not want after we thought about it, and thus resulting in two or three hires.

The big weakness there was the training of our doctors in "closing" and presenting our program. Therefore, we selected certain doctors to do the presentations and tried to train our recruiters better.

The skills and strategy for prospecting, qualifying, and closing is still a major continuing problem. We have to continually prospect in various ways - we even put in "head hunter" methods (giving \$100 a head) to our own doctors. There is a breakdown here because several of our doctors say they have referred people and then have heard nothing from the Recruiting Department. This is wrong. The Recruiting Department should be required to feed back what happened after they contacted each referral doctor - he was not interested, he could not make it at the time, etc. Not reporting back kills off the referring. I think we should try harder on this one. We have 170 doctors who could refer people they know,

but the Recruiting Department falls down on getting back to them. This is one good reason why the Recruiting Department has to come under the direction of Corporate (so that somebody like the Vice President of Administration checks on them at all times).

It is time that we try very hard to teach the doctors how to interview. We have to get them to clean up their offices, clean themselves up, and take the time to talk to the prospect. Put them into special offices with audio visuals to help them sell the doctor. (I do not know how these are being used, or if they are). All I can say is that we are spending a lot of time and money in prospecting and we are doing a poor job of qualifying, plus we are not closing well.

Again, money is not the answer. What we are selling is ease, professional development, quality of life, etc. This, of course, leads to recruiting people who may not be interested in management.

We should have monthly meetings (top management priority) with the Recruiting Department, which would include the Medical Directors. We could get the Recruiting Department in with the Medical Directors and the Heads of the Departments that are recruiting, and we could then have a meeting once a month for two hours on this.

We are figuring how much it costs us per hire, but we are not figuring our losses as to how much it costs us because the Recruiting Department is just getting a "warm" body in, and the Medical Directors, in their anguish and anxiety, hire them. Look at the characteristics of the people who have successfully been with us a number of years and you will find out what kind of people we are looking for.

Incidentally, I think we should figure out some kind of bonus for those people who are going to be working in the Senior Program to make it desirable to work there and cooperate.

RG:cb

Typed 12/6/82
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HMO DEFINITION - UTILIZATION CONTROL AND SYSTEMS

An HMO differs from fee-for-service inasmuch as, in fee-for-service, you get paid -- the physician, the hospital, the dentist or whoever it is -- a fee for each service. In an HMO, you get paid a prepayment, one set amount per month no matter what you do for the patient. Now, this completely reverses the incentives. In fee-for-service, in order to make a living, you have to make sure that you charge enough and provide enough services and the more services you provide, the more you make. In prepayment, you don't have to be concerned with that and you just practice medicine by keeping people well and your organization does better.

In an HMO you have to be concerned with productivity and make sure that there is no waste of time and that your costs are not out of line. It's more like running any kind of an American business -- you have income, you produce a service or a product, you have expenses, and, hopefully, you have a net.

I first got into this business because I thought there was something wrong with the fee-for-service method -- the sicker the person, the least able they were to pay, the more I charged them. I didn't like having to build up my bills and my services in order to meet my overhead. That's one difference between prepayment and fee-for-service.

The other principle is the difference between the HMO and the insurance concept. In insurance you simply pay for care and you are not concerned whether the patient or the consumer can find the care, or what quality it is when they find it. All you are concerned with in insurance is that you pay for the covered benefits. The HMO is significantly different because the HMO goes that one step further; that is, the HMO provides the service in addition to paying for it.

This is a big difference. That is, if the individual consumer doesn't like the doctor or feels that the doctor is not concerned -- if you're running an insurance company, you say "go find another doctor" -- if you're running an HMO, you had better do something about the doctor's attitude, look at the facilities or staff because you're on the hook for it. The one benefit that the consumer does not have in the HMO is the ability to go to any doctor or any hospital which is illusory because the patient goes only to the hospital where their doctor has staff privileges. They can't go to any hospital. Plus the fact that there is only a certain number of available doctors in the community.

If it is a small town, or if it is a section of town, what's there is there. Theoretically, they could go anyplace, but practically, they don't.

The several things that an HMO has as benefits as opposed to the benefit of going anyplace is that they have the benefit of pre-selecting physicians and of having all the services in one place. Part of our job is to make sure that we pre-select good physicians and that we provide a good quality of care. We have had to terminate physicians from time to time for various reasons -- they get sick, they have strokes, they abuse alcohol, they are mentally unstable, or they were just plain incompetent -- but they are still out there in the private sector, they don't lose their license.

We take the attitude that we get our share of top notch physicians and we get our share of the average physicians, but we do not get our share of the "not so good" physicians

We pre-select. If you are a new family coming into the community, there is a real problem in finding a pediatrician, an internist, an orthopedist (if you need it) and on and on. Or, you can come to the HMO and we have the surgeon available for you -- we make care available, accessible and we monitor the quality of care and provide all the services.

The third element is that the HMO provides a stop-loss for the consumer whereas an insurance usually provides a stop-loss for the insurance company. What that means is that an insurance company will pay so much for a procedure and then the consumer has to pay the rest. In an HMO, even if there is a co-payment, the person will pay only \$3.00 for an office call no matter how many services are provided and the HMO pays the rest.

Those are the three areas of significant difference between fee-for-service and HMO prepayment. The difference between supplying the service versus just paying for it; the difference between providing all the services, including preventive services such as health education, stress clinics, stop-smoking, weight reduction and just paying for definitive curative care and the guarantee of no additional prepayment to the consumer.

We must educate and reinforce to our physicians what an HMO is. I have just made a talk on that which we will use for orientation.

If we are an HMO and we're running it like any American business, we have to project our costs and I might digress a minute and say that an HMO is a complicated business with high risks. It is something like a financial business (like a bank or like an insurance company) where you have to project what inflation is going to be, in addition to what the risks are going to be down the road because if you promise to take of a person's care for a set amount, that's all you're going to get, and you better have projected it carefully. You have to take inflation, risk, management and investment changes into consideration. At the same time, you are like a service organization (a restaurant or a hotel or a hospital) and you have to provide service. And that means you have to be concerned for the patient, the place has to be clean and neat and people have to be courteous and efficient.

So what happens? What happens is that what we're concerned about here in Utah - we have around 40,000 people covered here in Utah. I have been in the field for over 20 years and with 40,000 people you should be generating a net surplus. I call it a net surplus in a non-profit corporation because it is really a profit, and I don't mind talking about profit. Mr. Drucker says that it is a moral obligation for a company to generate a profit and why? Because if you don't generate a profit, you can't grow, you can't provide new services, you can't provide new career opportunities for people, more income. It is like paddling a boat up stream; if you don't keep paddling, you go backwards. As the environment gets bigger and more complicated, you have to be able to grow and provide more services to cope with it.

In California, the income goes up like this (indicated on a chart) and the expenses go up and they go something like that (again noted on a chart) so that you generate a net surplus. At a certain point in time, you reach an incremental plateau where you are reaching top efficiency and you don't have to add anymore floor space and you don't have to add any more support staff and so forth and you keep getting incremental income.

Unfortunately, in Utah, it goes something like this (pointing to a chart). It goes up about the same rate, but then the expenses go up and they go something like this (pointing to a chart) and like that. So we're not controlling expenses in Utah. And, am here to tell you that it is the doctors that can be the main element in controlling expenses. As a physician I can tell you I can chop off 20% to 30% of any hospital bill for patients I have in the hospital by carefully considering whether I should order this test or that test, or whether I should give them this medication or that medication, whether I should order my lab work stat or whether I don't need it stat, o

whether they could go home a day earlier or not, or if they actually have to go to the hospital at all or whether I can do a neurological myself or should I send it out to the neurologist, or whether I can take the time and carefully do an examination of a patient's back and then send them to PT for therapy and have them back or whether I should send them off to the orthopedic surgeon, or whether I want to counsel the patient and so forth, and so forth.

There are many different things that you can do. And I know that a doctor can control medical costs anywhere from 30 to 50%.

When I first got into this business, I said - something dramatic for a fee-for-service group of ten doctors servicing the HMO. I said, you know I think the doctors are responsible for the patient's hospital bills; we tell them when to go in, when to leave, we write the orders in the hospital, etc. I tell you what we'll do. We'll pay patient's hospital bill. They give us one set amount per month and we'll pay their bill. My nine partners all but fell out the window -- all of them. So, I talked a long time to convince them to do that, and it worked.

Now we have to take a hard look at utilization. Not only do we have to look at utilization in the hospital and the ambulatory center, but we have to look at productivity and we have to look at waste. We're not alone in that. All American industry is talking about three things that bother them all the time: Inflation, Productivity and Government Interference. Inflation, productivity and government interference -- I don't care what business you are in, they are all worried about that.

When we went to matrix management, we developed Functional managers; Vice presidents, who are experts in certain areas, whether it be marketing, finance, provider services, operations and so forth. And then we have Regional Vice Presidents who are generalists and who are responsible for the particular region. The job of the Functional Vice President is to use their input into those particular services and areas. Now, during the last week we had our Marketing Vice President out here and we've had our Operations Vice President and we will have our Provider Vice President out.

Some of the things that came back in the reports from the Operations Vice Presidents were interesting and have a direct bearing on whether or not we're able to have a net surplus here. For instance, under systems re doctor production - "Doctors working with PAs get 15 minutes out of every scheduled hour to consult with the PA. Additional

they get half-hour in the morning and afternoon to return telephone calls. That's three hours out of eight hours that the doctor is not physically seeing patients. California NP's and PA's have the same MD signature requirements — both are working in the same physical area. In California, the doctor does the co-sign in between patients, during down time, etc., and is not scheduled out for this procedure. The NP has her doctor always available to see a difficult patient with them or to consult on any questions that the NP may have.

Currently, the wait time to see general practitioners is one day. This is because they have crossed out too many appointment times to be used for walk in or call ins. The walk/incall in numbers have dropped so there are not enough patients scheduled.

Now, as a matter of fact, you know that you always have a certain number of people that don't show. There is no real good reason to have to schedule out telephone time or walk in time. The way you schedule is you schedule the beginning, you schedule the end and you leave the middle empty and you gradually fill it in.

We have just done a study in California and we've done a study in Utah. It is very realistic. You just go through there with a chart and you look at every room twice per hour, all day long and do that for a whole week. Then you tabulate it up and you figure out what percentage of the time there was a doctor in the room with a patient, percentage with the patient in the room without a doctor, and what time there was nobody in the room. We found the same thing in both areas; that was, that 50% of the time, there was nobody in the room. Fifty percent of the time, there was nobody in the room — fifty. Now that means that we have bad scheduling.

I looked at it in California and what I found was nobody had enough rooms on Monday morning because everybody was taking off Tuesday, Wednesday or Thursday afternoon and anybody came in on Monday-Friday afternoon. So, there was not enough people using the facility on Tuesday, Wednesday and Thursday and too many on Monday. Plus, what they were doing was scheduling the same on Monday morning as they scheduled on other days and Monday mornings there were always lots of walk ins because people are saving up problems over the weekend. So, you just look at it logically and you don't schedule heavy on Monday mornings, you schedule maybe one patient every hour, every other hour and you give them the walk ins. You have to anticipate these things. There is really no sense building more facilities when 50% of the time the room you have are empty.

We have some basic systems in our organization. It is just like any systems approach — you don't have every McDonald's Hamburger have a different system, that wouldn't work. The exterior you can modify like you can modify one of the hotel chains, they modify their decor for the particular country they're in, but the systems all remain the same.

There are several systems that we use that have to be maintained and it is constant struggle to make sure that the systems are maintained. For instance, we have a system where the nurse or the medical assistant calls the patient. The way she should do it is, she should call the patient from the "call station" and she should always call them "Mr." or "Mrs." and never call them by their first name. Now, it may be very friendly and jolly, and all of that to call them by their first name, but I would rather take the chance of somebody thinking we're a little bit conservative than somebody being called "Joe" or "Jean" when they don't want to be called Joe or Jean. My 92 year old aunt goes in there and some 19 year old receptionist says, "Hello there, Mary". This woman used to be head of all the dormitories at a big university and she doesn't care for that. And the first thing that I learned in dealing with people is that you call them Mr. and Mrs., and if you're not sure they are Mrs., you call them Mrs. because it is worse to call out a Mrs., Miss, particularly when their belly is out to here, than it is to call a Miss, Mrs.

The nurse calls the patient on the intercom and then goes in and cleans up the room, then comes out again, and about that time, the patient is coming in the door — because the patient takes a little while to laydown a magazine, to catch their kid, and get into the room. If she does it the other way, in other words, if she cleans up the room first and then calls them and waits, you're going to have about 10 or 15% lost productivity, at least. There is a hell of a problem to get them to do this, to remember that, so it takes training and everything.

The worst possible thing is, to clean up the room, take the chart, go out in the waiting room and call the patient. Now they have to walk clear out in the waiting room, they have to wait for the patient to get up and come in, they have to pause two or three times and it is a complete waste. some people say it is more personal to do that. Well, everything is a trade off, you know, trade off not seeing three or four patients, the doctors sitting in the back.

Like there are other systems, patients come in, the receptionist processes the charts one at a time. They don't wait until they have five or six charts together and drop them in because the doctors and nurses are all waiting in the back to start. You

get one patient, boom, you drop the chart in, the nurse then takes and gets the doctor started. What happens is that it then takes time, it takes three, four or five minutes to process each chart. Now, if they waited for three, that's 15 minutes, and everything has shut down in the back end. And, it is a hard time getting people to do this, but they have to do this, but they have to do that system; they have to process them one at a time.

Other things, you take care of the entering patient first and the departing patient next. Because the entering patient, if you don't take care of them first, you stop the whole back end. The departing patient has already been taken care of, they can wait a few minutes. Simple little factors like that; the way the rooms are set up. We always set the rooms up - we measured the rooms out exactly, the table is a certain size, the chair is a certain size, you walk in, you sit down, the patient is sitting over here, you turn this way and examine the patient, you work from either side. Someone comes in and changes the room around - they stick the table in the corner and the first thing you see then is that the dressing cabinet is behind the table completely useless. You turn the desk so now you have to stumble over the patient sitting in the chair to get there.

Other things, we want the doctors to call their prescriptions to the pharmacist. The pharmacists are constantly trying to get the doctors to write the prescriptions. Well, you know what happens there, a certain number of prescriptions are illegible. The pharmacist has to chase the doctor around, or a certain number of prescriptions we all put down the wrong dosage for some reason, or they are out of it, or whatever. If you call the pharmacist and they are out of it, they are going to tell you they're out of it, but they can substitute something. Or, you say "What's the dosage", or the pharmacist now writes so that he can read it. And it is a very simple equation, the pharmacists make \$20,000 some a year, the doctors make \$40,000 some a year, and so it is half as expensive to have the pharmacist write it as it is to have the doctor write it, and twice as effective. So, they have to keep getting people to do this.

Another thing is that we want doctors to write up their charts in the room. Now, to me writing the chart up in the room indicates to the patients that you are concerned - you sit down and say "Mrs. Jones, when did you first start having this?" and then you write down the date, and bla bla bla. The other thing is, if you take a chart back to the lounge you may even have the theory that you'll see two patients and then write up the charts. That doesn't always happen. You see two patients and you're about to write up the chart, a telephone call comes in, and there are three or

four patients, then the chart is never written up.

TAPE

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to record this meeting

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